Ramsay Health Care UK Operations Limited

Oaklands Hospital

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Most staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

In Surgery;

- The proportion of theatre staff that had completed the higher level of adult safeguarding training, health and safety training and moving and handling training was below the hospital's expected target.
- The surgical services did not achieve national standards for waiting times from referral to treatment. However, the service had actions in place to improve this.

In Outpatients;

- The environment was not designed to meet the need of patients living with dementia or learning disabilities.

In Diagnostic imaging;

- The environment was not designed to meet the need of patients living with dementia or learning disabilities.
- The existing changing facilities in the waiting area were insufficient to maintain the privacy and dignity of patients and patients had to change in the room where they were receiving their scan, if necessary.
- The waiting environment was not large enough to accommodate a number of patients with mobility issues.
- The waiting times from referral to treatment and reporting times for images were not in line with national standards. However, the service had action plans in place to improve this.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care (Including older people's care)	Inspected but not rated	Medical care is a small proportion of hospital activity. We inspected medical care because the hospital provides some endoscopy procedures. The main service provided at the hospital was surgery. Where arrangements were the same, we have reported findings in the surgery section. We inspected but did not rate this service because we did not have sufficient evidence to rate medical care at this service.
Outpatients	Good	Outpatients is a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was safe, caring, responsive and well-led. We inspect but do not rate effective for outpatients.
Surgery	Good	The main service provided by this hospital was surgery. Where our findings on surgery – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery service. We rated this service as good because it was safe, effective, caring, responsive and well-led.
Diagnostic imaging	Good	Diagnostic imaging is a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was safe, caring, responsive and well-led. We inspect but do not rate effective for diagnostic imaging.

Summary of findings

Contents

Summary of this inspection

Background to Oaklands Hospital

Oaklands Hospital is operated by Ramsay Health Care UK Operations Limited. The hospital is located in Salford, Greater Manchester and provides a range of elective inpatient and day case surgical procedures for NHS and private fee paying adult patients, including general surgery, orthopaedic surgery, ophthalmology, ear, nose and throat (ENT), cosmetic surgery and bariatric (weight loss) surgery.

The hospital has an inpatient ward with capacity to accommodate 23 patients, 24 hours per day, seven days week. The day case unit consists of a surgical admissions unit with 3 individual bays and a separate day case ward with capacity to accommodate 8 patients in individual pod bays.

The surgical facilities include three operating theatres with laminar flow and a separate endoscopy / minor procedures theatre with a dedicated endoscopy decontamination suite.

The hospital provides a range of outpatient services for adults. The outpatient department has 7 consultation rooms.

The hospital provides a range of diagnostic imaging services such as X-ray, ultrasound and DEXA scanning. Mobile computerised tomography (CT) scans and magnetic resonance imaging (MRI) are also available on certain weekdays.

Oaklands Hospital has been registered with CQC since December 2010. The hospital director is the current registered manager for the service and has been in place since January 2023.

- The service is registered for the following regulated activities:
- Surgical procedures
- Treatment of disease, disorder or injury
- Family planning
- Diagnostic and screening procedures.

We previously inspected and rated Oaklands Hospital during July 2017. The report was published in December 2017. We rated the hospital as good overall, with a rating of requires improvement for safe and an overall rating of good for surgery and the outpatient and diagnostic services. We identified 6 regulatory breaches relating to Regulation 12 (safe care and treatment) and Regulation 17 (good governance) during the inspection.

We carried out a focussed responsive inspection of the surgical services during April 2021 (report published May 2021). We inspected but did not rate the service. We found the service had addressed the regulatory breaches identified during the previous inspection in July 2017 and no further regulatory breaches were identified during this inspection.

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

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. The inspection was unannounced. We carried out the on-site inspection on 21 November 2023 and 22 November 2023.

Summary of this inspection

During the inspection visit, the inspection team:

- Inspected the ward and theatre areas and the outpatients department at the main host hospital location.
- Inspected the main ward, day case and theatre areas, the endoscopy decontamination area, the outpatients department and the diagnostic imaging department.
- Spoke with 42 staff, including a housekeeping manager, ward nurses, healthcare assistants, theatre staff, outpatient staff, endoscopy staff, physiotherapists, pre-op assessment staff, the facilities manager, consultants, anaesthetists, the resident medical officer, the infection control lead nurse, the ward manager, the theatre manager, the radiology manager, the senior outpatients sister, the operations manager, the head of clinical services, the hospital director (also the registered manager) and the chair of the medical advisory committee.
- Looked at the training and recruitment files for 19 staff.
- Spoke with 13 patients and relatives.
- Looked at 16 patient records.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We did not identify any areas of outstanding practice as part of this inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

For Surgery:

- The service should take actions to improve mandatory training compliance for theatre staff, including for moving and handling, fire safety higher level adults safeguarding training
- The service should take appropriate actions to improve performance for patient waiting times from referral to treatment.

For Outpatients:

- The service should consider introducing learning disability and dementia-friendly adjustments into the department, as seen in other areas of the hospital.

For Diagnostic imaging:

- The service should consider introducing more adapted chairs in the waiting room for patients with mobility issues or who may not be able to sit in lower chairs.

Summary of this inspection

- The service should consider introducing learning disability and dementia-friendly adjustments into the department, as seen in other areas of the hospital.
- The service should take appropriate actions to improve performance for patient waiting times from referral to treatment.
- The service should take appropriate actions to improve reporting times for images.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (Including older people's care)	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated
Outpatients	Good	Inspected but not rated	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Diagnostic imaging	Good	Inspected but not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Inspected but not rated

Medical care (Including older people's care)

Safe	Inspected but not rated
Effective	Inspected but not rated
Caring	Inspected but not rated
Responsive	Inspected but not rated
Well-led	Inspected but not rated

Is the service safe?

Inspected but not rated

We inspected but did not rate safe because we did not have sufficient evidence to rate the service.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. Mandatory training was delivered through e-learning modules with some face to face training modules.

Managers monitored mandatory training on a monthly basis and alerted staff when they needed to update their training. The mandatory training was comprehensive and met the needs of patients and staff. Staff also completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Mandatory training compliance for staff in the endoscopy services was 95% and this was in line with the hospital's training completion target of 90%.

For our detailed findings on mandatory training, please see the safe section in the surgery report.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff in the endoscopy services had completed training specific for their role on how to recognise and report abuse. Records showed 100% of endoscopy staff had completed level 3 adults safeguarding training and 93% of staff had completed level 2 safeguarding children training

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

There had been 2 safeguarding incidents reported in relation to the endoscopy services since January 2023. We saw appropriate actions had been taken to protect the patients, including referral to the local authority safeguarding team and social services.

For our detailed findings on safeguarding, please see the safe section in the surgery report.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The endoscopy theatre and decontamination areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning schedules and daily and weekly checklists were in place and up to date, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.

There were enough hand wash sinks and hand gels. We observed staff following hand hygiene and 'bare below the elbow' guidance appropriately. Staff followed infection control principles including the use of personal protective equipment (PPE). All the staff we observed wore suitable PPE, such as gloves, aprons and visors while delivering care. Gowning procedures were adhered to in the endoscopy theatre areas.

The service generally performed well for cleanliness. Monthly audit results between May 2023 and October 2023 showed high levels of compliance. The endoscopy services achieved compliance scores of 96% for cleanliness of the environment and compliance scores between 97% and 100% for hand hygiene compliance during this period.

For our detailed findings on cleanliness, infection control and hygiene, please see the safe section in the surgery report.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. The endoscopy theatre, day case ward and decontamination areas were well-maintained, clutter free and provided a suitable environment for treating patients.

The decontamination of endoscopes was undertaken in a dedicated unit that had been accredited by the Joint Advisory Group on Gastro-intestinal Endoscopy (JAG). The facilities were compliant with health technical memorandum (HTM 01-06) management and decontamination of flexible endoscopes

The decontamination unit had appropriately segregated dirty to clean areas, with double wash sinks and two washer disinfectors in the ‘dirty’ area and a drying cabinet in the clean area. The drying cabinet could hold up to 10 scopes until required for use in the theatre. The clean scopes had an assigned expiry date and were reprocessed if not used within specified time frames.

Clean and contaminated endoscopes were transported between the theatre and decontamination unit using clearly labelled and sealed boxes. There was a clear flow of dirty to clean instrumentation and systems were in place to minimise cross-contamination and prevent the release of endoscopes not decontaminated appropriately.

Staff carried out daily safety checks of specialist equipment, including daily self-calibration and self-decontamination tests on the scopes decontamination equipment.

Staff carried out daily flushing of outlets and water lines in the decontamination unit. Water samples were collected on a weekly basis for external laboratory testing to check for the presence of microbes. Staff also carried out weekly protein tests on flexible endoscopes to check cleanliness of endoscopes by detecting proteins residues left behind following improper cleaning. We looked at water sample testing and protein test records over the past 3 months and these showed appropriate staff compliance with testing regimens and no untoward results found in test samples.

There was an electronic tracking and traceability system which enabled staff to promptly identify any affected scopes in the event of a failed test result. Labels were kept with individual scopes and also within patient records to enable tracking and traceability. There had been no instances of failed decontamination tests in the past 12 months.

There was a planned maintenance schedule in place that listed when equipment in the endoscopy services was due for servicing. Equipment servicing, calibration and portable appliance testing was carried out by external contractors. Service and maintenance records showed all equipment in the endoscopy services was within service and calibration due dates.

For our detailed findings on environment and equipment, please see the safe section in the surgery report.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

The service had an inclusion and exclusion criteria and patients admitted for treatment were generally healthy or suffered from mild systemic disease and considered to have a low risk of developing complications during the endoscopy procedure.

Patients were assessed by an anaesthetist and surgeon on the day of surgery to identify if there had been any changes to their medical condition since their initial consultation and a decision was made whether treatment could commence.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Patient records included risk assessments such as for venous thromboembolism (VTE – blood clots), pressure ulcers, nutritional needs, manual handling, risk of falls and infection control risks (including sepsis).

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used national early warning score systems (NEWS2) and carried out routine monitoring based on patients' individual needs to ensure any changes to their medical condition could be promptly identified.

We observed 2 endoscopy theatre teams undertaking the 'five steps to safer surgery' procedures, including the use of a modified World Health Organization (WHO) checklist. The theatre staff completed safety checks before, during and after the procedure and demonstrated a good understanding of the 'five steps to safer surgery' procedures.

Endoscopy theatre staff carried out safety huddles prior to commencing procedures and also conducted a de-brief at the end of the theatre list. We looked at the records for 3 patients who had undergone endoscopy procedures and these showed WHO safety checklists were completed correctly.

The routine safer surgery checklist audit for endoscopy services showed staff compliance was high and overall compliance of 99% had been achieved between May 2023 and October 2023.

Inspected but not rated

Medical care (Including older people's care)

The service had arrangements with local NHS trusts to allow patients whose health deteriorated during or after endoscopy procedures to be promptly transferred to a local acute trust if needed. There had been no instances in the past 12 months where patients required transfer to an acute hospital following endoscopy procedures.

For our detailed findings on assessing and responding to risk, please see the safe section in the surgery report.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. There were no vacancies relating to the endoscopy services.

The decontamination of endoscopes was carried out by the decontamination lead and 2 healthcare assistants, who were also part of the existing theatres team.

All endoscopy procedures were carried out by the existing surgical ward and theatre staff.

For our detailed findings on nurse staffing, please see the safe section in the surgery report.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. Endoscopy procedures were carried out by 5 gastroenterology consultants working under practicing privileges within the surgical services at the hospital.

For our detailed findings on medical staffing, please see the safe section in the surgery report.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. Records were stored securely. When patients transferred to a new team, there were no delays in staff accessing their records.

We looked at the electronic and paper-based records for 3 patients that had undergone endoscopy procedures. These were structured, legible, complete and up to date. Patient records showed that nursing and clinical assessments were carried out before; during and after surgery and that these were documented correctly. Patient risk assessments were reviewed and updated on a regular basis. Endoscopy reports were sent to the patient and their GP or other referring clinician.

For our detailed findings on records, please see the safe section in the surgery report.

Inspected but not rated

Medical care (Including older people's care)

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

We looked at the medicine administration records for 2 endoscopy patients and saw these were complete and up to date. Information such as patient allergy status was documented.

Staff followed systems and processes to prescribe and administer medicines safely. The endoscopy services were located within the main theatres at the hospital.

For our detailed findings on medicines, please see the safe section in the surgery report.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with provider policy.

There had been no patient deaths, never events or serious incidents reported by the endoscopy services during the past 12 months.

A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. The event has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.

The hospital reported 2 incidents relating to endoscopy services between November 2022 and November 2023. Both incidents related to staff / equipment issues and were graded as low patient harm.

Staff told us they received feedback about incidents reported through hospital-wide flash alerts, posters on notice boards and newsletters as well as through huddles and departmental meetings. The staff we spoke with were aware of their responsibilities regarding duty of candour legislation. There had been no incidents reported by the endoscopy services that met the threshold for implementing the duty of candour.

For our detailed findings on incidents, please see the safe section in the surgery report.

Is the service effective?

Inspected but not rated

We inspected but did not rate effective because we did not have sufficient evidence to rate the service.

Inspected but not rated

Medical care (Including older people's care)

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance, such as from The National Institute for Health and Care Excellence (NICE) and the Royal Colleges' standards.

The endoscopy decontamination unit had been accredited by the Joint Advisory Group on Gastro-intestinal Endoscopy (JAG). The facilities were compliant with health technical memorandum (HTM 01-06) management and decontamination of flexible endoscopes.

The hospital used care pathways that had been developed to meet best practice guidelines which staff followed to ensure patients received safe care and treatment. Theatre staff also used modified safety checklists for endoscopy procedures, which were based on based on World Health Organisation guidance..

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Changes to clinical practice, national guidance and policies were reviewed and discussed as part of medical advisory committee and clinical governance meetings.

For our detailed findings on evidence-based care and treatment, please see the effective section in the surgery report.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Specialist support from staff such as dietitians was available for patients who needed it. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Patients waiting to undergo endoscopy procedures were not left nil by mouth for long periods. Patients were given written information about starve times prior to commencing treatment.

All endoscopy patients were admitted as day cases and were provided with refreshments and snacks following their procedure. Staff took into account patients with specific cultural needs and were able to provide food based on their preferences.

For our detailed findings on nutrition and hydration, please see the effective section in the surgery report.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Inspected but not rated

Medical care (Including older people's care)

Patients could undergo endoscopy procedures under local or general anaesthetic. Staff prescribed, administered and recorded pain relief accurately.

Patients we spoke with told us they received pain relief soon after requesting it. One patient told us they did not want any local or general anaesthetic and the procedure was carried out in accordance with their preference.

Patient records showed that patients received the required pain relief and they were treated in a way that met their needs and reduced discomfort. Patients were also given information on how to manage pain symptoms and prescribed pain relief medicines following their discharge from the hospital.

For our detailed findings on pain relief, please see the effective section in the surgery report.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. Outcomes for patients were positive, consistent and met expectations, such as national standards.

The hospital submitted data to the Private Healthcare Information Network (PHIN) for all procedures (including endoscopy procedures). PHIN data did not identify any concerns and showed the service performed in line with national averages.

The service collated performance data for each consultant involved in endoscopy procedures. The information was used to monitor individual performance in areas such as Infection rates, mortality, never events, readmission and transfer rates.

We looked at the performance data for the 5 consultants involved in endoscopy procedures at this hospital. The data showed there had been no adverse outcomes or patient complications for endoscopy procedures in relation to any of the consultants between April 2022 and November 2023.

Managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits.

The service was accredited by the Joint Advisory Group on Gastro-intestinal Endoscopy (JAG). The most recent accreditation visit was undertaken in April 2023 and there were no concerns identified.

For our detailed findings on patient outcomes, please see the effective section in the surgery report.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers gave all new staff a full induction tailored to their role before they started work. Managers supported staff to develop through yearly, constructive appraisals of their work.

Inspected but not rated

Medical care (Including older people's care)

All endoscopy procedures were carried out by the existing surgical ward and theatre staff. We did not receive individual staff appraisal data for staff involved in the endoscopy services. However overall appraisal compliance was 90% for the ward staff and 86% for the theatre staff at the time of the inspection, demonstrating that most staff had completed their annual appraisals within the past year.

Consultants working under practicing privileges were required to submit evidence of their clinical appraisal annually from their substantive employer (such as the NHS trusts) and this was reviewed as part of the practicing privileges processes.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

The ward and theatre staff involved in endoscopy procedures and the decontamination of endoscopes were required to complete competency based training and assessments prior to undertaking endoscopy activities.

We looked at the training records for four staff from the ward and theatre areas that were involved in endoscopy procedures or the decontamination of endoscopes. The records showed they had undertaken specific competency-based training relating to undertaking endoscopy procedures and the decontamination of endoscopes. We saw evidence staff competencies were comprehensive and had been assessed by a trainer or line manager.

The surgical staff we spoke with told us they routinely completed and updated their competency-based training within their specialty area and felt confident to do their role. Staff involved in endoscopy services were positive about on-the-job learning and development opportunities and told us they were supported well by their line managers. They told us they received internal training and were also able to attend external training, such as national conferences and external courses to support their professional development.

For our detailed findings on competent staff, please see the effective section in the surgery report.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. All endoscopy procedures were carried out by the existing surgical ward and theatre staff.

For our detailed findings on multidisciplinary working, please see the effective section in the surgery report.

Seven-day services

Key services were not available seven days a week.

The service undertook a limited number of endoscopy, either as half day or full day sessions one or two days per week. All patients undergoing endoscopy procedures were admitted as day case patients with no overnight stay.

Patients were provided with an emergency contact number so they could contact the service at any time in case of a medical emergency or complication following discharge.

For our detailed findings on seven-day services, please see the effective section in the surgery report.

Inspected but not rated

Medical care (Including older people's care)

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on the day case unit. Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

For our detailed findings on health promotion, please see the effective section in the surgery report.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff understood how to obtain informed verbal and written consent from patients before providing care or treatment.

Staff clearly recorded consent in the patients' records. We looked at 3 endoscopy patient records which showed that patient consent had been obtained and planned care was delivered with their agreement. Written patient consent had been obtained as part of a two-stage consent process.

Staff made sure patients consented to treatment based on all the information available. The consent forms we looked at showed the risks and benefits of the specified surgical procedure were documented and explained to the patient.

For our detailed findings on consent, Mental Capacity Act and Deprivation of Liberty Safeguards, please see the effective section in the surgery report.

Is the service caring?

Inspected but not rated

We inspected but did not rate caring because we did not have sufficient evidence to rate the service.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Staff followed policy to keep patient care and treatment confidential. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Inspected but not rated

Medical care (Including older people's care)

Patients said staff treated them well and with kindness. We spoke with 3 patients in the endoscopy service during the inspection. They all told us they thought staff were friendly and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained. The comments received included “staff are helpful and very professional”, “staff are really good, friendly” and “nurse and consultant introduced themselves and were very friendly”

For our detailed findings on compassionate care, please see the caring section in the surgery report.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. We observed staff providing reassurance and comfort to patients before and after they had undergone their endoscopy procedure..

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Patients told us they were supported with their emotional needs and were able to voice any concerns or anxieties. The comments received included “I was nervous but staff were supportive helped calm nerves”, “staff were very comforting” and “staff were reassuring and supportive”.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff also supported patients to make informed decisions about their care.

The patients we spoke with told us they were kept informed about their treatment and staff were clear at explaining their treatment to them in a way they could understand. They told us the risks and benefits of their procedure were clearly explained to them so they could make an informed decision.

Patients gave positive feedback about the service. The comments received included “staff clearly explained everything about procedure” “consultant was really clear in explaining the risks” and “staff answered all questions clearly”.

Is the service responsive?

Inspected but not rated

We inspected but did not rate responsive because we did not have sufficient evidence to rate the service.

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

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Inspected but not rated

Medical care (Including older people's care)

The service planned and provided services in a way that met the needs of local people. The endoscopy services were mainly available for NHS patients over 18 years of age. The service had an inclusion and exclusion criteria and patients admitted for treatment were generally healthy and considered to have a low risk of developing complications during treatment. Patients could be admitted for day case endoscopy procedures under local or general anaesthetic.

Patients had an initial consultation to determine whether they needed endoscopy treatment. Where a patient was identified as needing an endoscopy procedure, staff were able to plan for the patient in advance, so they did not experience delays in their treatment when admitted to the hospital..

Patients undergoing endoscopy procedures did not routinely have a pre-operative assessment unless any risks had been identified at the initial consultation. All patients underwent a nursing assessment on arrival on the day of their procedure and were seen by the consultant or anaesthetist prior to their endoscopy procedure.

All endoscopy procedures were carried out by the existing surgical ward and theatre staff. Planning for endoscopy procedures was undertaken as part of routine daily safety huddles and planning meetings across the day case unit and theatre areas.

Facilities and premises were appropriate for the services being delivered. All endoscopy procedures took place in a dedicated endoscopy theatre. The endoscopy decontamination area was located next to the endoscopy theatre, which were both located within the main theatres department at hospital.

Patients were admitted to the day case unit on the day of their procedure. The day case unit consisted of a surgical admissions unit with 3 individual bays and a separate day case ward with capacity to accommodate 8 patients in individual pod bays. All patients undergoing endoscopy procedures were admitted to the surgical admissions unit. Patients that had endoscopy procedures under local anaesthetic returned to the surgical admissions unit for assessment and discharge. Patients under general anaesthetic were returned to the day case unit following recovery.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Patients were cared for in individual rooms and there had been no same-sex accommodation breaches reported during the past 12 months.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The service had information leaflets available in languages spoken by the patients and local community. Information leaflets were given to patients prior to undergoing treatment. Information leaflets in different languages or other formats (such as braille, large print or 'easy read' format) could be printed upon request.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

All endoscopy procedures were carried out by the existing surgical ward and theatre staff.

Inspected but not rated

Medical care (Including older people's care)

For our detailed findings on meeting people's individual needs, please see the responsive section in the surgery report.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers and staff worked to make sure patients did not stay longer than they needed to. All patients undergoing endoscopy procedures attended the hospital as day cases.

During the inspection, we did not observe any significant concerns relating to patient access and flow. The environment in the day case ward and theatres appeared calm and relaxed. Patient admissions were staggered throughout the day and the patients we spoke with told us they had not experienced any delays on the day of their procedure.

Managers and staff worked to make sure that they started discharge planning as early as possible. Discharge arrangements, such as how the patient would get home, were discussed as part of the initial assessment process. Patients were assessed prior to discharge on the day of their procedure and were given information on how to access further support or guidance if needed. Patient records showed staff had completed a discharge checklists and information about the endoscopy procedure was given to the patient and other healthcare professionals, such as the patient's GP.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The hospital reported most patients undergoing endoscopy procedures were treated within 6 weeks from initial referral. Where patients waited longer than 6 weeks from referral to treatment, this was mostly due to patient choice.

The hospital was not able to provide data on cancellations specifically for the endoscopy services. This was reported as part of the overall surgical services.

For our detailed findings on access and flow, please see the responsive section in the surgery report.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The endoscopy patients we spoke with told us they had been given information leaflets detailing how to complain or raise concerns prior to undertaking surgery.

Staff in the endoscopy services understood the policy on complaints and knew how to handle them. Staff told us that information about complaints was discussed during daily safety huddles and at routine team meetings to aid future learning.

The hospital had not received any complaints relating to endoscopy procedures during the past 12 months.

All endoscopy procedures were carried out by the existing surgical ward and theatre staff.

Inspected but not rated

Medical care (Including older people's care)

For our detailed findings on learning from complaints and concerns, please see the responsive section in the surgery report.

Is the service well-led?

Inspected but not rated

We inspected but did not rate well-led because we did not have sufficient evidence to rate the service.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

All endoscopy patients were admitted into the surgical day case admissions on the day of their procedure and received care and treatment by the existing surgical ward staff. All endoscopy procedures were carried out in the endoscopy theatre by the existing theatre staff and 5 consultants working under practicing privileges.

The decontamination of endoscopes was undertaken by a decontamination lead and 2 healthcare assistants, who reported to the theatre manager and also worked in the main surgical theatres.

The endoscopy services staff we spoke with told us they understood the reporting structures clearly and described their line managers as approachable, visible and who provided good support.

For our detailed findings on leadership, please see the well-led section in the surgery report.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The hospital's values and clinical priorities were clearly displayed on notice boards across the day case unit and theatre areas. They had been cascaded to staff across the services and the theatres and endoscopy staff we spoke with had a good understanding of these.

For our detailed findings on vision and strategy, please see the well-led section in the surgery report.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Inspected but not rated

Medical care (Including older people's care)

The endoscopy services staff and consultants we spoke with were highly motivated, patient-focussed and spoke positively about working in the endoscopy services. They told us there was a friendly and open culture and they were supported with their training needs by their line managers.

All the staff we spoke with were aware of the whistleblowing policy and understood how to contact the freedom to speak up guardian if needed.

For our detailed findings on culture, please see the well-led section in the surgery report.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Staff in the endoscopy services participated in routine monthly ward and theatre staff meetings. Information around endoscopy procedures was also discussed at routine clinical governance and medical advisory committee meetings.

The endoscopy services received support and oversight from an independent authorised engineer for decontamination, who was registered with the Institute of Healthcare Engineering and Estate Management (IHEEM). The independent engineer provided guidance and support and carried out annual compliance review of flexible endoscope decontamination facilities. The most recent review took place in April 2023 and the service was assessed as fully compliant with applicable Joint Advisory Group on Gastro-intestinal Endoscopy (JAG).and Royal Colleges' standards.

The corporate provider decontamination lead also provided support and oversight of endoscopy services and carried out annual audits to check compliance against corporate provider policies and national standards. The most recent audit (November 2022) showed the endoscopy services had achieved 100% compliance.

We saw evidence policies and procedures relating to the endoscopy services were up to date and reflected national guidance. Staff in the endoscopy services regularly received competency-based training. Staff had completed risk assessments relating to the decontamination of flexible endoscopes and there were systems in place for the safe storage and management of reagents as well as routine testing and maintenance of decontamination equipment and facilities.

We looked at the recruitment files for a consultant gastroenterologist and involved in endoscopy procedures, the decontamination lead and a healthcare assistant involved in the decontamination of endoscopes.

We found evidence that suitable checks had been carried out prior to commencement of employment in the files we looked at. This included identification checks, proof of qualifications and mandatory training, at least two employment references, Disclosure and Barring Service (DBS) checks and professional body registrations and revalidations.

For our detailed findings on governance, please see the well-led section in the surgery report.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The key risks relating to the endoscopy services were recorded on a departmental risk register that were incorporated into the hospital wide risk register. The risk register showed that key risks were identified and control measures were put in place to mitigate risks. Risks had a review date and an accountable staff member (such as the theatre manager) responsible for managing that risk.

Staff were aware of how to record and escalate key risks on the risk register. A risk scoring system was used to identify and escalate key risks to the hospital risk register.

Key risks and risk register entries relating to the endoscopy services were reviewed at monthly departmental meetings as well as routine clinical governance, medical advisory committee and senior leadership team meetings.

There was a structured programme of audit covering key processes such as infection control, patient records and medicines management. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through routine team meetings, safety huddles, performance dashboards and newsletters.

For our detailed findings on management of risk, issues and performance, please see the well-led section in the surgery report.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

We did not identify any concerns in relation to the security of patient records during the inspection. Endoscopy patient records were accessible for staff and could be easily retrieved. Electronic records were stored on computers with controlled access.

Staff completed data security awareness training as part of their mandatory training. Staff could access information such as policies and procedures in paper and electronic format. The policies we looked at were version-controlled, up to date and had periodic review dates.

For our detailed findings on information management, please see the well-led section in the surgery report.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff involved in the endoscopy services told us they received good support and regular communication from the ward and theatre managers. Staff routinely participated in team meetings and took part in daily huddles across the areas we inspected.

The services routinely engaged with patients and their relatives to gain feedback from them.

We saw evidence there was routine formal and informal engagement and collaborative working with stakeholders, such as the independent authorised engineer for decontamination as well as routine engagement with the corporate provider endoscopy decontamination lead and endoscopy leads across the provider's other hospitals.

Inspected but not rated

Medical care (Including older people's care)

For our detailed findings on engagement, please see the well-led section in the surgery report.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Staff told us the endoscopy services had a positive culture that was focussed on learning and improvement. We saw evidence of learning and improvement resulting from findings from audit results, incidents and complaints and shared learning was cascaded to staff to improve the service.

The endoscopy services and decontamination facilities were JAG accredited and had achieved 100% compliance in recent internal and external audits.

Good

Outpatients

Safe	Good
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Good

Is the service safe?

Good

We previously rated outpatients and diagnostic imaging as one core service. We now rate them separately. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

The service had 97% overall completion of all mandatory training by eligible staff for the year 2023 to 2024. The target was 95%.

Consultants completed mandatory training with their substantive NHS employer and provided annual confirmation of completion of this training to the hospital in line with the practising privileges policy.

For our detailed findings on mandatory training, please see the safe section in the surgery report.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse.

All clinically registered staff in the department were trained to level three in children and adult safeguarding with all other staff trained to level two. Levels one and two training were undertaken annually. Training included female genital mutilation (FGM) and child sexual exploitation. All eligible staff in the department were trained in levels 1 and 2 safeguarding adults and safeguarding children. Adult safeguarding level 3 had been undertaken by 86% of eligible staff. This equated to one staff member.

There was no level four trained person in the department but there was a level four trained safeguarding lead in the hospital who was easily accessible, and staff knew how to contact them.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the department although patients were asked not to bring children to the hospital unless a baby that would require feeding.

For our detailed findings on safeguarding and the hospital safeguarding lead, please see the safe section in the surgery report.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. The waiting areas, examination room, diagnostic areas and changing rooms were all visibly clean and we saw completed cleaning rotas.

Staff followed infection control principles including the use of personal protective equipment (PPE). The department provided staff with personal protective equipment (PPE) such as gloves and aprons. We observed all staff wore PPE where necessary.

The service completed monthly hand hygiene audits. The audit results showed that from May to October 2023, compliance with hand hygiene in the outpatients department ranged from 83.3% to 100% and in the physiotherapy department from 98% to 100%.

Staff cleaned equipment after patient contact. Staff completed hand hygiene before seeing a patient, wore suitable personal protective equipment and cleaned equipment after each use. Staff were observed to be bare below the elbows.

The hospital carried out a 50 steps cleaning audit monthly. Compliance with this audit for the outpatients department from May to October 2023 was between 80% and 97.1%. For the physiotherapy department this was between 74.1% and 96%.

The department had not reported any hospital acquired infections in the previous year.

Good

Outpatients

Each clinical area had a foot operated clinical waste bin, sharps bins were present which were clean, not over filled and secure.

Hand sanitiser was available for staff and patients throughout the department, staff were observed using this both before and after patient contact.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service had enough suitable equipment to help them to safely care for patients. The service had suitable facilities to meet the needs of patients' families. The outpatient department and pre-operative assessments were on the first floor. There was a reception and waiting area with plentiful seating and a separate wating area outside the pre-operative assessment rooms and phlebotomy room; there were 8 consulting rooms, one of which was an ophthalmology room; 2 pre-operative assessment rooms; 1 phlebotomy room and 1 treatment room.

The physiotherapy department was located in a separate building next to the main hospital and was located on the ground floor.

The service had enough suitable equipment to help them to safely care for patients.

Staff carried out daily safety checks of specialist equipment. Equipment in the department was clean and servicing contracts were in place. We saw that equipment had been serviced and the service record was in date.

Emergency resuscitation equipment was available for the service on the first floor corridor. The outpatient department shared a resuscitation trolley with the radiology department. The resuscitation trolley was clean, and contents were secured with a tag. The trolley was checked daily by ward staff and monthly by an external company.

The service had suitable facilities to meet the needs of patients' families.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Patients underwent pre-operative assessment prior to undergoing surgical procedures. All patients requiring inpatient admission had a face to face pre-operative assessment. Patients undergoing certain day case procedures had a telephone assessment if deemed as low risk.

The pre-operative assessment process included a review of patient’s medical histories, medication, and social, health and mobility needs. Patients were assessed against the hospital’s inclusion and exclusion criteria to determine if they were eligible for treatment at the hospital.

The pre-op nurses undertook patient risk assessments, such as for venous thromboembolism (VTE – blood clots) nutrition, falls, pressure care, stop-bang (sleep apnoea), infection risks (including MRSA screening), and dementia risks.

Good

Outpatients

As part of the process, the pre-operative assessment nurses carried out vital observations and arranged for bloods and diagnostic tests (such as electrocardiogram) if required, as well as MRSA screening for elective surgical patients.

Patients were given verbal and written information about their planned care and treatment. The pre-operative nurses also confirmed patient consent and identified any other personal needs or preferences.

Staff responded promptly to any sudden deterioration in a patient's health. There were emergency call bells throughout the hospital. The department had a policy for recognising the deteriorating patient. This included escalation processes. Staff could give examples of when they had used the escalation process, this included calling the resuscitation team or resident medical officer (RMO) beginning observations and getting the resuscitation trolley. The RMO, together with the responsible consultant, would then decide to manage the patient at the hospital or authorise emergency transfer to a local NHS Trust.

A resuscitation team in the hospital was named every morning. This included a team leader, airway and compressions clinicians and a runner. Details of the team were displayed in the department at the start of each day.

During clinic times, consultants were in the outpatient department and able to assist with any medical emergencies. The hospital also had a resident medical officer (RMO) present in the hospital 24 hours a day. Staff told us that they would bleep the RMO if they had any concerns about patient deterioration. If needed, staff would call an ambulance to transfer patients to an NHS hospital and staff told us they would handover all relevant patient information to the paramedics.

The outpatient department had access to a resuscitation trolley, emergency peri-arrest and anaphylactic shock kits for adults and children. Children were not seen as patients in outpatients but may have attended with parents or carers on occasion. Depending on their role, all clinical staff in the department had completed basic life support or intermediate life support.

Outpatient department staff received patient's records, including risk information, from the medical records team on the day of their appointments. For new patients, they advised that the hospitals' booking team recorded any relevant risk information they had identified during the booking process. Consultants then recorded patient risks during their first consultation and made staff in the department aware.

Staff knew about and dealt with any specific risk issues and shared key information to keep patients safe when handing over their care to others.

The department used a World Health Organisation (WHO) safety checklist for minor operations. Staff recorded patients' vital observations before, during and after their procedures to check for signs of deterioration.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

Good

Outpatients

The outpatient service had enough staff to keep patients safe. The service included registered nurses, health care assistants and non-clinical administration staff. The manager adjusted staffing levels daily according to the number of clinics running and the number of patients attending. Bank staff were used to cover additional shifts and periods of leave and sickness absence, if required, but the service had low rates of bank nurse usage. Bank staff were familiar with the service.

The outpatient service and pre-operative assessments had no vacancies. There was an outpatient manager; 2 sisters/ charge nurses; 6 staff nurses; a senior health care assistant and 4 healthcare assistants. The service was overstaffed by 1 whole time equivalent member of staff.

The physiotherapy service had enough staff to keep patients safe. The service included physiotherapists and non-clinical administration staff.

The physiotherapy service had no vacancies. There was a physiotherapy manager; physiotherapy team leader; 1 senior physiotherapist; 5 physiotherapists and an administrative assistant.

In the outpatient department, one of the healthcare assistants was undergoing training to become a nurse associate that meant they would be able to carry out a lot of the tasks of the registered nurses. There were plans to start a second healthcare assistant on the course when the first had completed it.

Each morning, the heads of each department attended a senior leadership huddle meeting. Managers told us that they would use this meeting to escalate any last minute staffing issues.

In terms of medical staffing, there were 65 surgeons who carried out pre and post-operative outpatient clinics; 5 physicians who only carried out outpatient clinics; 2 cardiologists and 1 audiologist who only carried out outpatient clinics. They all worked in the service under practicing privileges.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Staff used electronic patient records for recording pre-op assessments, patient risk assessments, initial consultation summaries, discharge information and follow up consultations, When patients transferred to a new team, there were no delays in staff accessing their records.

We looked at the pre-op assessment records and pre and post-operative outpatient consultation records for 6 patients. These were structured, legible, complete and up to date.

Patients were given a post-operative follow up appointment with the consultant at routine intervals if required. Patient records showed patients had been offered follow up appointments and they were seen by a consultant within specified timelines.

Patient notes were comprehensive and all staff could access them easily. The hospital's medical records team prepared patient records in advance of patients' appointments

Records were stored securely.

Good

Outpatients

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

The hospital had an on-site pharmacy team. There were no controlled drugs in the outpatient department.

Staff followed systems and processes to prescribe and administer medicines safely.

All medicines were stored safely in locked cupboards.

We found the fridge for medicines was in good working order. Room and fridge temperatures were recorded daily and were within a safe range.

In the event of an emergency, the department had an adult anaphylaxis box which was in date, it was secured with a number tag by the pharmacy.

Staff stored and managed all medicines and prescribing documents safely.

For details about pharmacy stocks and controls please see the surgery report.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff were aware of how to raise concerns, report incidents and near misses in line with the hospital policy. Staff reported incidents via an electronic system. The department was proactive in reporting no-harm incidents and near-misses as well as incidents where harm may have occurred.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers shared learning with their staff about never events that happened elsewhere. There had been no never events and no serious incidents reported in the outpatients or physiotherapy departments in the previous 12 months though learning from never events and serious incidents in other Ramsay hospitals were shared at staff meetings and in safety huddles.

Staff understood the term duty of candour, which was covered in a mandatory training module for staff to complete. There was a duty of candour policy in place and staff were able to tell us what their responsibility was when something had gone wrong.

Learning from incidents was shared in staff meetings. There was a monthly update of the hospital's incidents and lessons that had been learnt.

Managers debriefed and supported staff after any serious incident.

Good

Outpatients

From December 2022 to November 2023 the outpatient department had reported 59 incidents, 58 of which were no or low harm incidents with one classed as moderate.

Th physiotherapy department reported no incidents within the same reporting period.

Is the service effective?

Inspected but not rated

We inspected the effective domain but we do not rate this for outpatient services.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance. We saw evidence that department processes reflected national guidance such as World Health Organisation (WHO) surgical safety procedures in minor operations and Chartered Society of Physiotherapy (CSP) in the physiotherapy team and The National Institute for Health and Care Excellence.

The hospital's overarching policies were produced and reviewed centrally by the hospital group. Staff were able to access all policies on the hospital's computer system. Outpatient department leads also displayed or stored some of these in the department office so that staff could access information quickly. These included policies and processes about safeguarding and mental capacity.

Staff told us that they received information about policy changes by email and that managers would discuss significant changes with them at team meetings. The hospital leadership team provided staff with an overview of daily senior leadership team meetings which included a key messages section. Managers told us that senior leaders would share urgent changes to practice with them in this meeting so they could let staff know straight away.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Patents received local anaesthetic during minor operations. Staff explained they would check with patients that the area was numb before the procedure started and regularly ask them about pain whilst the procedure took place.

Staff told us that patients attending dressings or other clinics could access the wound care lead or consultants if they were feeling pain, they could then be prescribed pain relief if it was appropriate and safe to do so. Staff were aware that patients might suffer pain if they had not been taking their medicine as prescribed, they were able involve the pharmacy team in supporting the patient to take their medicines properly.

Good

Outpatients

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The department participated in hospital wide and department specific audits. Departmental audits included surgical safety checklist for minor operations. Managers shared and made sure staff understood information from audits. We saw that managers included audit results in team meeting agendas.

Performance reported outcomes measures (PROMs) data was reported at hospital level.

For our detailed findings on patient outcomes, please see the effective section in the surgery report.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. There were opportunities for health care assistants to upskill to become nursing associates, reducing the demands on registered nurses in the department.

Managers gave all new staff a full induction tailored to their role before they started work. New staff underwent a supernumerary period of 6 to 8 weeks, dependent on experience and there were induction checklists in place. Staff also completed a preceptorship booklet to reflect on their initial induction and training.

Managers supported staff to develop through yearly, constructive appraisals of their work. We saw that all eligible staff had received an annual appraisal.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. We saw that staff were encouraged and supported to undertake training in specialisms, for example, one nurse was undertaking a university course in mental health and another nurse had studied wound care and had developed a wound care proforma for use by staff in the department.

Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Good

Outpatients

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Patients could see all the health professionals involved in their care at one-stop clinics, so, for example, following an outpatient appointment, an x-ray could be completed, or bloods taken.

Staff worked across health care disciplines and with other providers when required to care for patients. Relevant information was shared with the patient's GP or NHS acute hospital where necessary.

We observed staff working well together as a team, the department had a positive and respectful atmosphere.

Staff told us they believed there were very good lines of communication within the department. Important messages were shared each morning at a hospital wide multidisciplinary management meeting.

Seven-day services

Key services were available seven days a week to support timely patient care.

The department facilitated clinics throughout the day and in the early evenings on Monday to Saturday each week. Managers planned clinics in line with consultant availability and patient demand.

The physiotherapy department was able to run clinics on evenings and weekends using bank staff to meet patient demand and minimise wait times.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had some information promoting healthy lifestyles and support in patient areas, such as smoking cessation and advice about the menopause.

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle. Consultants would take a clinical history of the patient in consultations and were able to give them relevant advice to improve their general health.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care and knew how to access the policy on Mental Capacity Act.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The process for patient consent was detailed in a corporate consent policy. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff made sure patients consented to treatment based on all the information available.

Good

Outpatients

When patients could not give consent, staff followed policy to ensure decisions were made in their best interest, taking into account patients' wishes, culture and traditions. Staff were aware of the hospital's mental capacity policy and could explain what would happen if a person did not have the capacity to consent to any procedure. They told us they would not continue but would seek further guidance from the referring doctor.

Staff told us that patients who lacked full capacity were generally accompanied by a relative or carer.

Staff clearly recorded consent in the patients' records.

Staff received and kept up to date with training in the Mental Capacity Act.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005 and they knew who to contact for advice.

For patients who could not speak English there was an interpreting service available that could be used to help with the consent process.

Is the service caring?

Good

We previously rated outpatients and diagnostic imaging as one core service. We now rate them separately. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff introduced themselves to patients and took time to ask how they were feeling. Staff asked patients how they felt about procedures and if they had any questions.

Staff clearly explained procedures and the time it would take to the patient. We witnessed staff interacting with patients before and throughout their appointment. Staff gave patients positive feedback during their appointment where appropriate and continued to ask how the patient was doing. Patients were reminded to tell staff if they wanted a procedure to stop at any time.

Patients said staff treated them well and with kindness.

Reception staff were kind, sensitive and caring when speaking to patients.

Staff followed policy to keep patient care and treatment confidential. Staff maintained privacy and dignity by ensuring blinds and doors and modesty curtains were closed when patients entered the room.

Staff understood and respected the individual needs of each patient.

Chaperones were available to support patients during procedures if needed.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Staff maintained constant interaction with patients throughout their appointment, they talked patients through procedures and went at a pace that suited the patient. Patients who may need more time for appointments due to complexities such as mobility issues or pain were highlighted during the booking process so that additional time could be added to their appointment.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Patients told us that staff were very reassuring. Patients told us that everything had been explained to them very well and they were well informed about how long they would have to wait for any results or surgery.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff could explain what they would do if they recognised a patient who may need additional support to understand and be involved in their care.

Staff talked with patients, families and carers in a way they could understand.

Staff supported patients to make informed decisions about their care.

There was a range of information on the services website which was available to patients. This information explained available treatments and services, why they may be needed and what to expect.

Patients and their families could give feedback on the service and their treatment in a number of ways and staff supported them to do this. There were posters in the waiting area which highlighted to patients how to give feedback.

Patients generally gave positive feedback about the service.

Good

Outpatients

Examples of positive comments received were “very friendly and informative; reassuring. Felt better after visit” regarding physiotherapy and “was treated really well here at Oaklands, Doctors and Nurses were amazing.” regarding outpatients.

For detailed information about patient feedback received, please see the surgery report.

Feedback comments were passed on to staff to reassure them that the patients had a good experience. Negative comments were analysed and used to make improvements to the department.

For details of the Private Healthcare Information Network (PHIN) outcomes on care for Oaklands Hospital, please refer to the surgery report.

Is the service responsive?

Good

We previously rated outpatients and diagnostic imaging as one core service. We now rate them separately. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The hospital offered services to self-funded or privately insured adults as well as NHS patient referrals on a contractual basis. This meant that patients were not just from the local area as patients from further away could refer themselves if they wanted to.

Managers planned clinics in line with consultant availability and patient demand. Patients we spoke with said they did not wait long for their consultation.

Staff told us that demand had increased for almost all clinics.

Managers monitored and took action to minimise missed appointments and ensured that patients who did not attend appointments were contacted.

Facilities and premises were appropriate for the services being delivered. The design of the environment met the needs of patients and was accessible for patients with mobility issues via lift access. The main waiting area for outpatients was spacious enough to accommodate those patients waiting to be seen

There were refreshments available and the hospital had a restaurant on site.

For information about the suitability of the premises, please refer to the surgery report.

Good

Outpatients

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Patients with complex needs were provided with increased appointment times to allow staff time to provide additional support and these could be at the beginning or end of a clinic.

Staff gave examples of patients with learning disabilities or living with dementia who had attended for appointments. Patients had been accompanied by carers for support.

The department was not designed to meet the need of patients living with dementia. There were no dementia friendly or learning disability adjustments in the department, such as signage or clocks as were evident in other areas of the hospital.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Interpreter and translation services were available.

For further information about meeting people's individual needs, please see the surgery report.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure most patients could access services when needed and received treatment within agreed timeframes and national targets. Patient appointments were booked by the administrative team, who assessed patients' individual needs and scheduled an appointment with adequate time.

The outpatient department ran 3 session clinics, 6 days a week (morning, afternoon and evening). From November 2022 to November 2023, outpatient activity had increased by 36%. The service had carried out some expansion work to provide additional capacity. This included the conversion of two offices into pre-assessment consultation rooms with the existing pre-assessment consultation rooms reverting to outpatient consultation rooms. This increased the outpatient clinic capacity by 25%.

A further two physiotherapy bays had also been created by repurposing an area of the medical records storeroom.

Managers worked to keep the number of cancelled appointments to a minimum, managers made sure they were rearranged as soon as possible and within national targets and guidance.

If a patient's appointment was cancelled, administrative staff would call the patient on the same day and rebook an alternative appointment as soon as possible. The number of patients who did not attend their appointment was low.

Good

Outpatients

Managers and staff worked to make sure patients did not stay longer than they needed to. Staff said they did their best to keep clinics running on time and would apologise to patients if they had to wait past the start time of their appointment. The hospital collected data on appointment times, time of patient arrival and time that patient was seen to identify those clinics that regularly overran or difficulties in patients arriving on time for appointments.

The hospital collected data about how long patients waited to be seen after they were referred and then how long they waited for treatment after being seen in outpatients, see the main surgery report for details on referral to treatment times.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with knew how to raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Posters in the waiting area directed patients on how to make a complaint.

Managers investigated complaints and identified themes. The diagnostic manager told us that the service took complaints seriously and tried to resolve complaints at the point of care. They told us that patients were always offered a chance to report their complaints formally if they remained unhappy.

Staff understood the policy on complaints and knew how to handle them.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice. Managers told us about examples where patient feedback had been used to improve practice.

For further information on complaints please refer to the surgery report.

Is the service well-led?

Good

We previously rated outpatients and diagnostic imaging as one core service. We now rate them separately. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

For detailed findings on leadership, please see the well-led section of the surgery report.

Good

Outpatients

The services had a clear leadership structure. There was an outpatient manager for the department. They oversaw the day to day running of the service. They were an experienced manager. They were supported by two sisters, one of whom managed the pre-assessment service and the other the outpatients clinics.

Physiotherapy was run by a physiotherapy manager who was supported by a physiotherapy team leader.

Staff told us that they felt well-supported by the departmental manager and had opportunities to learn and progress. They also told us that senior leaders were very visible in the hospital, knew all the staff and they encouraged staff to speak to them about any issues.

The managers told us that they had the opportunity to and had undertaken a Ramsay Hospitals course in management.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

For detailed finding on vision and strategy, please see the well-led section of the surgery report.

The outpatient and physiotherapy departments had a local strategy in place that fed into the hospital wide strategy where there were 5 strategic objectives for 2023/24. These were based on patient safety, engagement, development and retention of staff, improvement to clinical service delivery and financial performance.

The hospital's values and clinical priorities were clearly displayed on notice boards across the outpatient and physiotherapy departments.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

For detailed findings on culture, please see the well-led section of the surgery report.

Staff that we spoke with were motivated and positive about their work and told us that they felt supported and valued. They felt that they worked together well as a team to provide good patient-centred care.

The last staff survey showed that, in the department, a high number of respondents were proud to work for the organisation.

Staff told us that senior managers had an open-door culture and encouraged staff to raise concerns. There was freedom to speak up guardian in the hospital and staff knew who they were.

Good

Outpatients

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

For our detailed findings on governance, please see the well-led section of the surgery report.

There was a clear governance structure for the department.

The manager attended the clinical governance committee meetings with other departmental heads to review policies and procedures, discuss incidents and complaints and any safety issues.

Heads of departments held monthly meetings with set agendas.

There were monthly staff team meetings within the department. This meeting had a standard agenda that included a review of actions; business matters; departmental updates; continued professional development updates; learning; regulatory updates and people issues. We reviewed the minutes from the last team meeting and found them to be well-ordered and comprehensive.

We looked at the recruitment files for 3 consultants (who worked across both the surgical and outpatient services), an outpatients nurse and a healthcare assistant from the outpatient services.

We found evidence that suitable checks had been carried out prior to commencement of employment in the files we looked at. This included identification checks, proof of qualifications and mandatory training, at least two employment references, Disclosure and Barring Service (DBS) checks and professional body registrations and revalidations.

The hospital reported there were no outstanding queries relating to practising privileges. The 3 consultants' files we looked at showed up to date appraisals and indemnity certificates and the consultants were listed on the GMC specialist register relevant to their specialty area.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

For our detailed findings on management of risk, issues and performance, please see the well-led section of the surgery report.

The key risks relating to the outpatient and physiotherapy services were recorded on a departmental risk register that was incorporated into the hospital wide risk register. The risk register showed that key risks were identified and control measures were put in place to mitigate risks. Risks had a review date and an accountable staff member (such as the department

Staff were aware of how to record and escalate key risks on the risk register. A risk scoring system was used to identify and escalate key risks to the hospital risk register.

Good

Outpatients

Key risks and risk register entries relating to the services were reviewed at monthly departmental meetings as well as routine clinical governance, health and safety, information governance, medical advisory committee and senior leadership team meetings.

There was a structured programme of audit covering key processes such as infection control, patient records and medicines management. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through routine team meetings, safety huddles, performance dashboards and newsletters.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

For our detailed findings on information management, please see the well-led section of the surgery report.

There were systems in place for the safe storage, circulation and management of electronic and paper-based records such as patient records, performance reports, audit records and meeting minutes.

Staff completed information governance training as part of their annual mandatory training. Records showed 100% of eligible staff had completed this training.

The manager reported there had been no data breaches that were reportable to the Information Commissioner's Office (ICO).

Electronic systems (such as to store records and manage patient appointments) required password access. Diagnostic scan results, reports and images were stored electronically and could be accessed by staff in other parts of the hospital, such as during routine outpatient consultations.

Staff could access information such as policies and procedures in paper and electronic format. The policies we looked at were version-controlled, up to date and had periodic review dates.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

For our detailed findings on engagement, please see the well-led section of the surgery report.

Staff felt well informed about what was going on within the hospital and hospital group and received any updates daily at morning huddles. There was a monthly staff newsletter.

Representatives from the department were part of a staff engagement circle that met to talk about interdepartmental issues and events.

There were mental health first aiders for staff.

Good

Outpatients

The service engaged with patients to gather feedback in a number of formats and make improvements.

Feedback from complaints was shared regularly with staff and managers.

Staff could give examples of changes that had been made based on patient feedback.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The outpatient department had a commitment to continuous improvement. We saw evidence of learning and improvement resulting from findings from audit results, incidents and complaints and shared learning was cascaded to staff to improve the service.

Managers encouraged innovation by staff.

One staff member had written a wound care and management proforma that staff followed in order to manage wounds correctly and ensure that the most appropriate dressings were used and changed at appropriate intervals. It was hoped that this could be rolled out in other Ramsay Group hospitals.

Good

Surgery

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

Is the service safe?

Good

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. However, the proportion of theatre staff that had completed health and safety training and moving and handling training was below the hospital's expected target.

Staff received and kept up-to-date with their mandatory training. Mandatory training was delivered through e-learning modules with some face to face training modules.

Managers monitored mandatory training on a monthly basis and alerted staff when they needed to update their training. Managers maintained a training matrix which identified the type and frequency of training required for different staff groups across the hospital.

The mandatory training was comprehensive and met the needs of patients and staff. The core mandatory training for all staff covered key topics such as fire safety, health and safety, equality, human rights, workplace diversity, resuscitation, moving and handling, infection control, hand hygiene, information governance, general data protection regulation (GDPR), safeguarding adults and children and conflict resolution.

Clinical mandatory core training (for clinical staff only) included key topics such as point of care testing, blood transfusion, intravenous (IV) administration, dementia awareness, venous thromboembolism (VTE – blood clots) risk assessment, medicines management (medicines calculation), patient consent and life support training.

Mandatory training compliance for all staff across the hospital was 91%. Mandatory training compliance was 96% for the ward staff and 93% for theatre staff. Overall training compliance was in line with the hospital's training completion target of 90%. However, mandatory training compliance for theatres staff was below the hospital's target for 3 individual training topics: moving and handling (67%), fire safety (76%) and level 3 adults safeguarding (71%). The theatre manager was aware that training compliance needed to improve and had plans in place to improve this.

Clinical staff also completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Records showed 80% of staff across the surgical services had completed dementia awareness training, 100% of staff had completed consent training (including mental capacity) and 96% of staff across the surgical services had completed the Oliver McGowan training on learning disability and autism.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, the proportion of theatre staff that had completed the higher level of adult safeguarding training was below the hospital's expected target.

Staff in the surgical services had completed training specific for their role on how to recognise and report abuse. Records showed 100% of ward staff and 71% of theatre staff had completed level 3 adults safeguarding training.

Staff followed safe procedures for children visiting the ward. The service did not provide any care and treatment for patients under 18 years of age. However, staff were required to complete safeguarding training for adults and children. Records showed 96% of staff across the surgical services had completed level 1 safeguarding children training and 93% had completed level 2 safeguarding children training.

Staff also received training in female genital mutilation, modern slavery and prevent (counter-terrorism strategy) training as part of their safeguarding training.

Most staff across the surgical services had completed safeguarding training in line with current intercollegiate guidance for adults and children. However, the proportion of theatre staff that had completed adult safeguarding level 3 training was below the hospital's training completion target of 90%. The theatre manager was aware that safeguarding training compliance needed to improve and had plans in place to improve training compliance.

The hospital had a named safeguarding lead and the head of clinical services was the deputy safeguarding lead for the service. Both had completed adult and children's safeguarding (level four) training and staff knew how to contact them for support and guidance.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had safeguarding policies available to support staff and these could be accessed on the hospital's intranet. Instructions for staff for making referrals to external agencies, such as the local authority safeguarding team were displayed in the areas we inspected.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

There had been 5 safeguarding incidents reported across the hospital since January 2023. None of these were attributable to the care and treatment provided by the service and related to staff identifying vulnerable patients that required further support, such as from social services.

Good

Surgery

One of the 5 reported safeguarding incidents related specifically to the surgical services, and we saw appropriate actions had been taken to protect the patient, including referral to the local authority safeguarding team, social services and the patient's general practitioner (GP).

Safeguarding incidents were reviewed as part of routine monthly clinical governance meetings to identify trends and look for improvements to the services.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Staff received mandatory training in infection prevention and control as well as additional training in hand hygiene and aseptic non-touch technique. There were infection prevention and control policies and procedures in place which provided further guidance for staff.

The hospital had appointed an infection prevention and control (IPC) lead nurse who oversaw infection control processes and provided support for staff. The head of clinical services was the director of infection prevention and control (DIPC) for the service. The hospital also had a number of infection control champions in place to provide support and guidance for staff.

The hospital had not reported any healthcare-acquired infections or outbreaks during the past 12 months. Patients underwent Methicillin-resistant Staphylococcus aureus (MRSA) screening and pre-admission checks for other infection risks, such as Clostridium difficile (C. difficile), prior to admission for surgery. We saw evidence of this in the patient records we reviewed during the inspection.

Staff worked effectively to prevent, identify and treat surgical site infections. The hospital reported 3 surgical site infections relating to hip surgery and 3 infections relating to knee surgery during the past 12 months. The proportion of surgical site infections relating to hip and knee procedures was better than the average when compared with the corporate provider's other hospitals nationally.

The hospital also reported 17 other surgical site infections (excluding hip and knee procedures) during the past 12 months. The proportion of other surgical site infections (0.3%) was slightly higher than the average when compared with the corporate provider's other hospitals nationally (0.2%). The hospital had an improvement plan in place to reduce surgical site infections. This included actions around increased staff education and training and to improve processes for antimicrobial stewardship.

The ward, day surgery and theatre areas were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning schedules and daily checklists were in place and up to date, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment. Staff cleaned equipment after patient contact using alcohol wipes and chlorine-based disinfectant and labelled equipment to show when it was last cleaned.

There was a service-level agreement in place with an external provider for the sterilisation of reusable surgical instruments and procedure packs. Staff told us they did not have any concerns relating to the sterilisation or availability of surgical instruments.

The housekeepers were responsible for cleaning bed spaces in between patients, cleaning the general environment and replenishing hand gels and personal protective equipment stocks. There was a programme in place to routinely flush all water outlets to minimise the risk of Legionella and we saw checklists were completed to document flushing activities. The ward and theatres underwent periodic deep cleaning and additionally if there had been any contamination (such as after patients with infection risks).

There were enough hand wash sinks and hand gels. We observed staff following hand hygiene and 'bare below the elbow' guidance appropriately. Visitors were encouraged to wash their hands.

Staff followed infection control principles including the use of personal protective equipment (PPE). All the staff we observed wore suitable PPE, such as gloves, aprons and visors while delivering care. Gowning procedures were adhered to in the theatre areas. Clean linen was appropriately stored and segregated in dedicated cabinets. Patients identified with an infection could be isolated in single rooms in the ward areas. Staff used appropriate signage to protect staff and patients if there was a patient that had been isolated.

Infection control and hand hygiene audits took place on monthly basis across the wards and theatre areas. These included checks of the cleanliness of the general environment and equipment and hand hygiene compliance.

The service generally performed well for cleanliness. Audit results between May 2023 and October 2023 showed the surgical ward and theatre areas achieved compliance scores between 84% and 96% for cleanliness of the environment and compliance scores between 82% and 100% for hand hygiene compliance. Where cleanliness issues were identified, remedial actions were put in place and these were followed up at the next audit to minimise the risk of spread of infection. Where poor hand hygiene compliance was identified this was discussed with individual staff members to improve compliance.

The IPC lead nurse had also carried out an IPC governance and assurance audit during July 2023 and an IPC environment infrastructure audit during August 2023 across the whole hospital and 100% compliance had been achieved.

There was an infection control champions group monthly meeting to monitor infection control processes, which reported to the hospital-wide monthly clinical governance meetings. The infection control champions group included representatives from all departments across the hospital, including estates and pharmacy. Staff also had access to a corporate provider-level consultant microbiologist, who could be contacted for any day to day concerns or queries to support the hospital teams.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The surgical ward, day case and theatre areas were well maintained, free from clutter and provided a suitable environment for treating patients. The design of the environment followed national guidance and promoted accessibility in all areas.

There was secure access to all clinical areas. The theatres had effective systems for the storage and management of surgical implants and surgical procedure packs.

Good

Surgery

All the patient rooms in the ward areas were single rooms, each with ensuite walk-in shower and toilet facilities. Each patient room had call bells and auxiliary outputs (such as oxygen and medical gases). Patients could reach call bells and we saw that staff responded quickly when called.

All the equipment we saw (such as hoists, anaesthetic machines and patient monitoring equipment) were clean, well maintained. Equipment such as trolleys and stands were visibly clean and staff used disinfectant wipes to clean and decontaminate equipment. Anaesthetic machines were checked daily by the theatre staff.

The service had enough suitable equipment to help them safely care for patients. Staff told us equipment needed for care and treatment was readily available and any faulty equipment could be replaced promptly. Staff had access to specialist equipment, such as bariatric equipment or specialist pressure relieving equipment.

There was a planned maintenance schedule in place that listed when equipment was due for servicing. Equipment servicing, calibration and portable appliance testing was carried out by external contractors. The servicing and calibration of the facilities (including air flow systems, lifts, fire safety systems and auxiliary plant room) was overseen by the maintenance manager. Planned maintenance and servicing of patient equipment (such as monitoring equipment, anaesthetic machines and hoists) was managed by the ward and theatre managers.

We looked at the equipment schedule and this showed the majority of equipment was within service and calibration due dates. The hospital reported 5 minor items of equipment (such as theatre lighting) that were overdue for planned servicing, and these were all scheduled for service during December 2023.

We saw evidence that fire safety systems, fire extinguishers, medical gases and auxiliary supplies, water storage facilities, theatre air filtration systems and electrical and gas systems underwent routine servicing and planned maintenance with up to date certificates in place from external certified contractors. The emergency power backup generator was tested weekly and underwent servicing every 6 months.

There were suitable arrangements in place for fire safety, including an up to date external fire risk assessment and clear instructions for staff to follow in the event of a fire. We also saw an up to date external asbestos risk assessment was in place for the hospital.

Single-use, sterile instruments and consumable items were stored appropriately, and we saw these were within their expiry dates. Staff handled, stored and disposed clinical waste safely. Sharps bins were appropriately stored and labelled correctly.

Hazardous substances (such as cleaning chemicals) were stored in a locked cupboard. Staff maintained control of substances hazardous to health (COSHH) risk assessments relating to substances stored on the premises.

Staff carried out daily safety checks of specialist equipment. Emergency resuscitation equipment for adults and children was available in all the areas we inspected, and this was checked by staff. We saw that daily and weekly equipment check logs were complete and up to date. All the emergency resuscitation trolleys we saw were tagged to minimise the risk that items could be tampered with. Emergency medicines were kept in grab boxes and the expiry dates were checked on a routine basis.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Good

Surgery

The surgical services had an inclusion and exclusion criteria that identified patients who could or could not be admitted for treatment. The inclusion criteria excluded certain patients, such as patients with an American Society of Anaesthesiologists (ASA) classification level three or above (complex health needs).

Patients on renal dialysis, patients with certain blood disorders, patients with certain cardiac and respiratory conditions or general patients with a body mass index (BMI) greater than 45 were not eligible for surgery at the hospital and were referred NHS acute services that could accommodate these patients. Patients undergoing bariatric (weight loss) surgery could be admitted for treatment with a BMI up to 55 (female patients) and up to 50 for male patients.

Patients were assessed by an anaesthetist and surgeon on the day of surgery to identify if there had been any changes to their medical condition since their initial consultation and a decision was made whether treatment could commence.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

On admission to the surgical ward or day case unit and before surgery, staff carried out risk assessments to identify patients at risk of harm. Patient records included risk assessments such as for venous thromboembolism (VTE – blood clots), pressure ulcers, nutritional needs, manual handling, sleep apnoea, risk of falls and infection control risks.

Staff also screened patients for suspected sepsis and utilised the sepsis six care bundle if required. There had been no instances of patients identified with sepsis in the past 12 months.

Staff knew about and dealt with any specific risk issues. Patients at high risk were placed on care pathways and care plans were put in place so they received the right level of care. We looked at six patient records and these showed that patient risks were assessed, reviewed regularly and escalated appropriately when required.

Patients undergoing bariatric (weight loss) surgery were assessed as part of a multidisciplinary approach with clinical, psychological and dietitian input prior to and post-surgery.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used national early warning score systems (NEWS2) and carried out routine monitoring based on patients' individual needs to ensure any changes to their medical condition could be promptly identified. A hospital-wide NEWS2 audit in June 2023 achieved 90% compliance, indicating high levels of staff compliance in the identification and escalation of deteriorating patients.

Shift changes and handovers included all necessary key information to keep patients safe. Staff handover records were based on the SBAR (situation, background, assessment, recommendation) tool and handover discussions included any patient safety risks.

We observed 3 theatre teams undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures.

Theatre staff carried out safety huddles prior to commencing surgical procedures and also conducted a de-brief at the end of the theatre list. We looked at the records for 6 patients who had undergone surgery and these showed surgical safety checklists were completed correctly.

Good

Surgery

There was a routine audit to check staff compliance against the safer surgery checklist across the theatre areas. Audit results showed staff compliance was high and overall compliance of 99% had been achieved between May 2023 and October 2023.

The surgical services had arrangements with local NHS trusts to allow patients whose health deteriorated during or after surgery to be promptly transferred to a local acute trust if needed. Where a patient's health deteriorated, staff were supported with medical input to stabilise patients prior to transfer by ambulance.

There had been 9 transfers of surgical patients during the past 12 months. In each case, the patients were appropriately assessed and stabilised by the medical staff and transferred in accordance with the hospital's policies.

The theatres kept two bags of O negative emergency bloods that were suitably stored and monitored daily.

The consultants and anaesthetists were trained in advanced life support. The resident medical officer (RMO) was trained in advanced life support and was on site at all times. Records showed 100% of theatre staff had also completed advanced life support (ALS) training and all the ward staff had completed either immediate life support (ILS) or basic life support (BLS) training in line with the provider's policy. There was always at least one person in theatres with advanced life support training at all times, in line with Resuscitation Council UK guidelines.

The hospital had a resuscitation team that was on site 24 hours per day and led by the resident medical officer. The resuscitation team held a daily safety huddle and carried out routine simulation exercises to test the team's response times. There had been no instances where patients required emergency resuscitation during the past 12 months.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses, theatre staff and healthcare assistants needed for each shift in accordance with national guidance.

The ward manager could adjust staffing levels daily according to the needs of patients. The ward manager told us they only carried out planned elective surgery and this allowed the ward and theatre teams to plan staffing requirements and staff rotas up to 6 weeks in advance and allocate additional staff for patients with higher dependency needs.

The number of nurses and healthcare assistants matched the planned numbers. The ward had a full staffing establishment with no current vacancies. The theatre manager told us there were 3 nurse vacancies in the anaesthetic and recovery areas and recruitment for the vacant posts was on-going.

The ward staffing establishment was for at least 4 nurses and 3 healthcare assistants on the day shift and at least 2 nurses and a healthcare assistant on the night shift. The day case unit was staffed by the ward staff with at least one nurse and one healthcare assistant on the day case unit when theatre sessions took place.

The theatre teams were suitably staffed in line with national guidelines, such as the Association for Perioperative Practice (AfPP) and the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines for safer staffing.

Good

Surgery

Staffing levels in the ward and theatre areas were maintained through the use of regular bank or agency staff. Managers limited their use of bank and agency staff and requested staff familiar with the service. Where bank or agency staff were used, managers made sure all bank and agency staff had a full induction and understood the service.

Staff sickness and turnover rates were monitored by the service and were generally low. The overall staff sickness rate across the hospital was 4.4% between November 2022 and October 2023 and this was comparable to the average when compared with the corporate provider's other hospitals nationally (4.6%). The staff turnover rate (all staff) across the hospital was 21.5% (compared with 18.7% average across corporate provider's other hospitals nationally) during this period.

The ward and theatre managers carried out daily staff monitoring and escalated staffing shortfalls due to unplanned sickness or leave as part of the daily hospital-wide and departmental huddles. Nursing staff handovers took place during daily shift changes and these included discussions about patient needs and any staffing or capacity issues.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had enough medical staff to keep patients safe. Surgical procedures were carried out by a team of consultant surgeons and anaesthetists over a broad range of specialties, such as orthopaedic surgery, urology, ophthalmology, gastroenterology and general surgery.

There were 65 consultant surgeons and 44 consultant anaesthetists working under practicing privileges across the surgical services. The majority of consultant surgeons worked across both the surgery and outpatient services at the hospital.

The consultants and anaesthetists were responsible for their individual patients during their hospital stay and were required to provide on-call support during evenings and weekends. Patients were reviewed by a consultant on a daily basis.

Medical cover on the wards was provided by resident medical officers (RMO) who worked alternate shifts for one week. During their shift, the RMO was based at the hospital 24 hours per day for that week. The RMO was resident on site and was available on-call during out-of-hours.

During their shift, the RMO was responsible for providing medical cover on the ward and day case unit. Their duties included the monitoring of patients in the ward areas and prescribing medicines, if needed.

The RMO told us they received induction training and were provided with policies and procedures applicable to their role, such as for patient discharge or patient transfer. The RMO also told us they received good support from the ward staff and could contact the on-call consultant or anaesthetist responsible if further advice or support was needed.

The RMO and ward staff had access to the on-call consultant and anaesthetist and also had a list of contacts for all the consultants and anaesthetists for each patient and told us they could be easily contacted when needed.

Good

Surgery

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Records were stored securely.

Staff used electronic patient records for recording initial consultations, pre-op assessments, intra-operative care pathways, patient risk assessments, care plans, discharge information, patient assessments and for medical and nursing notes. When patients transferred to a new team, there were no delays in staff accessing their records. The electronic patient record system was also used for storing scanned paper-based patient records, such as signed consent forms.

Staff also used paper-based records for standardised nursing activities, such as for daily observations and nutritional care. We saw that observations were well recorded, and the observation times were completed at least every 4 hours or more frequently depending on the level of care needed by the patient.

We looked at the electronic and paper-based records for 6 patients. These were structured, legible, complete and up to date. Patient records showed that nursing and clinical assessments were carried out before; during and after surgery and that these were documented correctly. Patient risk assessments were reviewed and updated on a regular basis. Multidisciplinary staff interventions were recorded in daily notes and these were up to date.

Staff carried out routine patient record audits to check for accuracy and completeness of records. This included medical record audits (ward), VTE compliance and patient recovery observation records. Audit results showed compliance ranged between 88% and 99% between May 2023 and October 2023, indicating high levels of compliance for accuracy and completeness of patient records.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Staff stored and managed all medicines and prescribing documents safely and securely, in line with the provider's medicines management policies.

Staff carried out daily checks on controlled drugs and routine medicine stocks (including fluid bags) to ensure that medicines were reconciled correctly. We looked at a sample of controlled drugs and found the stock levels were correct, and the controlled drug registers were completed correctly. The head of clinical services was the controlled drugs accountable officer for the service.

The ward manager told us they did not keep medicines in fridges within the ward but had access to the medicines fridge in the outpatient department if required. We saw that medicines that required storage at temperatures between 2ºC and 8ºC were appropriately stored in medicine fridges in the theatres. These were checked daily and the medicines we checked were stored at the correct temperatures. Staff monitored the temperature of the clinic room in the surgical ward and theatres on a daily basis.

Fridge and room temperature logs showed that temperatures had been within the expected range during October and November 2023. There was a system in place for staff to notify the maintenance or pharmacy teams where medicine fridge or treatment room temperatures exceeded the maximum temperature range.

Good

Surgery

The hospital used paper-based prescribing and medicines administration records. The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff completed medicines records accurately and kept them up-to-date. We looked at the medicine administration records and discharge medicine records for 5 patients and saw these were complete and up to date. Information such as patient allergy status and patient weight was documented.

Medical gases were appropriately and securely stored in each area we inspected. The medicine administration records also showed patients who required oxygen therapy had oxygen prescribed and this was appropriately documented.

Staff were supported by the hospital's pharmacist and a pharmacy technician during normal working hours on weekdays, who carried out routine audits and maintained medicine stocks. The ward and theatre managers could also access emergency medicines during out of hours if emergency medicines were required.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff followed current national practice to check patients had the correct medicines. The pharmacist was present on the ward daily and reviewed all medical prescriptions, including antimicrobial prescriptions and to take home discharge medicines, to identify and minimise the incidence of prescribing errors.

The ward and theatre staff and the pharmacy technician were responsible for maintaining and replenishing controlled drugs, routine medicines and fluid bags and carried out routine checks for stock levels and expiry dates. All the routine medicines we saw were kept safely in locked cabinets and were within their expiry dates.

The pharmacist carried out a range of routine medicines management audits that were mainly reported at hospital-level. The audits undertaken included medicines reconciliation, safe and secure medicines storage and controlled drugs and medicines prescribing audits (including antimicrobial prescribing).

We looked at the results for these audits for the period between May 2023 and October 2023. Overall compliance for medicines reconciliation, safe and secure medicines storage and controlled drugs audits ranged between 93% and 100%, indicating high levels of staff compliance with medicines management processes.

The medicines prescribing audit (October 2023) showed overall compliance of 77%. There was an action plan in place to improve compliance and this was planned for follow up at the next scheduled audit.

Medicines management processes across the hospital were reviewed as part of routine monthly medicines management committee meetings.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. The service had policies and guidance in place for staff on how to identify, categorise by level of harm and report incidents.

Good

Surgery

Staff raised concerns and reported incidents and near misses in line with provider policy. All incidents, accidents and near misses were logged on an electronic incident reporting system. The hospital had implemented a new electronic incident reporting system to replace the previous electronic reporting system in August 2023.

Incidents were reviewed and investigated by staff with the appropriate level of seniority, such as the clinical governance lead or departmental managers. The hospital director, head of clinical services and clinical governance lead reviewed all new incidents on a daily basis to identify any serious incidents that required immediate actions, such as escalation to the corporate provider or external reporting to organisations such as the Care Quality Commission or NHS service commissioners. New incidents were also discussed at daily hospital-wide huddles.

There had been no 'never events' reported in relation to the surgical services during the past 12 months. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

There had been 171 incidents across the hospital between December 2022 and November 2023. This included 105 incidents that related to the surgical services. There had been 2 incidents relating to patient deaths and 6 incidents of moderate or above harm reported by the surgical services during this period. The remaining incidents relating to the surgical services were graded as low or no patient harm.

The most frequent reasons for incidents reported by the surgical services were patient management (43 incidents) and staff/equipment issues (39 incidents).

The patient death incidents occurred during April 2023 and August 2023. Both incidents occurred after the patient had been discharged from hospital following surgery. The April 2023 incident had been investigated by the service to determine root cause and identify learning and improvement. The root cause investigation for the August 2023 incident was in progress at the time of the inspection. The 6 serious incidents rated moderate or above harm related to complications during surgery, post-operative complications and surgical site infection.

We looked at the root cause analysis investigation report for the patient death incident from April 2023 and a sample of three root cause analysis investigation reports over the past 6 months for incidents reported as moderate or above harm. We saw the investigation reports were completed appropriately and showed remedial actions had been put in place to minimise the risk of reoccurrence. The investigation reports included information such as chronology of events, details of treatment undertaken, root cause leading to incident, duty of candour details, action plans and details of any good staff practice to aid learning.

Staff told us they received feedback about incidents reported and that this was used to improve practice and the service to patients. Learning from incidents was shared through hospital-wide flash alerts, posters on notice boards, bulletins and newsletters and this included learning from incidents that had occurred at the provider's other hospitals. Meeting minutes showed that incidents were also discussed during routine senior leadership team, medical advisory committee, clinical governance and departmental meetings so shared learning could take place.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. 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. The investigation reports we looked showed evidence that formal duty of candour had been undertaken.

Good

Surgery

There was a system in place to ensure safety alerts relating to patient safety, medicines and medical devices were cascaded to staff and responded to in a timely manner.

The senior managers were aware of their responsibility to report notifiable incidents to the Care Quality Commission (CQC) and other external organisations.

The provider's patient safety incident response policy outlined the hospital's approach for managing incidents in line with NHS England's Patient Safety Incident Response Framework (PSIRF).

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance, such as from The National Institute for Health and Care Excellence (NICE) and the Royal Colleges' standards.

The national early warning system (NEWS2) was used to assess and respond to any change in a patient's condition, in-line with NICE guidance CG50. All patients were risk assessed on admission for their risk of venous thromboembolism (VTE – blood clots), in line with the NICE guidance QS201. The theatre teams also used the 'five steps to safer surgery' checklists, based on World Health Organisation guidance. Staff also used modified safety checklists for certain surgical procedures, such as for ophthalmology and endoscopy procedures.

The surgical services had implemented the national safety standards for invasive procedures (NatSSIPS). These are standards that support healthcare organisations in providing safer care and to reduce the number of patient safety incidents related to invasive procedures.

The hospital used care pathways that had been developed to meet best practice guidelines which staff followed to ensure patients received safe care and treatment. Care pathways for bariatric (weight loss) surgery were based on national guidelines such as NICE clinical guideline CG189: obesity: identification, assessment and management and British Obesity and Metabolic Surgery Society (BOMSS) guidelines.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Patients with psychological and emotional needs were identified as part of the initial assessment process and routinely referred for psychological assessment prior to undertaking certain procedures, such as for bariatric (weight loss) surgery or cosmetic surgery.

Good

Surgery

Changes to clinical practice, national guidance and policies were reviewed and developed centrally by the corporate provider and cascaded to the hospital and shared with staff. Policies based on best practice and clinical guidelines were developed nationally and cascaded to the hospital for implementation. We saw evidence through minutes for medical advisory committee, clinical governance and departmental ward and theatre team meetings that changes in practice and guidance updates were routinely discussed.

Staff told us policies and procedures reflected current guidelines and were easily accessible through the provider's intranet. We looked at a selection of the policies, procedures and care pathways and these were up to date and based on current national guidelines.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Specialist support from staff such as dietitians was available for patients who needed it.

Patients told us they were offered a choice of food and drink and spoke positively about the quality of the food offered. Patients ordered their meals and drinks through the ward support staff a number of times during the day. The hospital had menu options available for patients with specific requirements, such as vegetarian, halal and kosher meals. We observed patients being supported to eat and drink. Drinks were readily available and were in easy reach of patients.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We looked at six patient records which showed staff carried out an assessment of patients' nutritional requirements and used the Malnutrition Universal Screening Tool (MUST). Where patients were identified as at risk, staff fully and accurately completed patients' fluid and nutrition charts where needed.

Patients waiting to have surgery were not left nil by mouth for long periods. Patients were given advice on starve times for certain procedures as part of their pre-operative assessments. The patients we spoke with told us they were given clear advice on starve times prior to admission and were offered drinks and snacks as soon as their procedure was completed.

The hospital had recently trialled the 'Sip Til Send' policy, in which patients undergoing bariatric (weight loss) surgery were provided with one standard glass of water, on the hour, every hour, prior to surgery. The hospital reported this had led to a reduction in post-operative nausea and vomiting for this group of patients, and reduced patient length of stay.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used pain assessment tools to monitor pain symptoms at regular intervals. Acute pain symptoms were managed by the resident medical officer and surgical consultants.

Good

Surgery

Patients received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately. Patient records showed that patients received the required pain relief and they were treated in a way that met their needs and reduced discomfort. The patients we spoke with told us they received good support from staff and their pain relief medicines were given to them as and when needed.

Patients were also given information on how to manage pain symptoms and prescribed pain relief medicines following their discharge from the hospital.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. Outcomes for patients were positive, consistent and met expectations, such as national standards.

The hospital submitted data to the Private Healthcare Information Network (PHIN). This is an independent, government-mandated source of information about private healthcare which supports patients to make better-informed choices of care provider. PHIN data did not identify any concerns and showed the service performed in line with national averages.

The national joint registry (NJR) data for 2021/22 showed that patient outcomes, revision rates and mortality rates for hip, knee and shoulder surgery at the hospital were within the national averages.

Performance reported outcomes measures (PROMs) data was reported at hospital level. Outcomes data for April 2021-March 2022 reported to PHIN showed 100% of patients reported they had improved since their hip replacement and knee replacement surgery and the hospital performed better than the England average.

The hospital reported the most recent PROMs data for the period between July 2023 and September 2023 showed outcomes following hip, knee and shoulder procedures were better than national averages.

The service collated performance data for each consultant involved in surgical procedures. The information did not specify patient outcomes but was used to monitor performance in areas such as the number of complications (readmissions after surgery, returns to theatre and surgical site infections. We looked at the performance data for three surgical consultants which showed low instances of patient complications.

Managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits. Audit findings were reviewed as part of routine departmental staff meetings and as part of the monthly clinical governance meeting and medical advisory committee meetings, held every three months.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers gave all new staff a full induction tailored to their role before they started work. Newly appointed staff had an induction and their competency was assessed before working unsupervised. Bank and agency staff also had inductions before starting work.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff told us they received an annual appraisal. The overall staff appraisal completion rate across the hospital was 91%. The hospital's end of year appraisal completion target was 90%.

Records showed 90% of ward staff and 86% of theatre staff had completed their annual appraisal at the time of the inspection and further staff appraisals were scheduled to take place.

Consultants working under practicing privileges were required to submit evidence of their clinical appraisal annually from their substantive employer (such as the NHS trusts) and this was reviewed as part of the practicing privileges processes. Where consultants did not have substantive employment within the NHS, the provider arranged for their appraisal to be completed by a designated responsible officer.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Formal qualifications, professional body registrations and specialist register entry requirements were reviewed as part of routine staff recruitment and practicing privileges processes.

The ward and theatre staff were required to complete role-specific clinical skills competency assessments as part of their induction process. Ward and theatre staff also received competency based training and assessments covering a range of topics, such as use of equipment, taking bloods, medicines administration and reconciliation, moving and handling, cannulation, catheter line insertion and blood transfusion.

Staff could also participate in routine training workshops and refresher courses relevant to their role as part of their ongoing training and development. Surgical first assistants underwent formal university qualifications and specific competencies to undertake the role.

We looked at the training records for four staff from the ward and theatre areas and these showed they had undertaken competency-based training that had been assessed by a trainer or line manager. The surgical staff we spoke with told us they routinely completed and updated their competency-based training within their specialty area and felt confident to do their role. Staff were positive about on-the-job learning and development opportunities and told us they were supported well by their line managers

The service had 2 surgical first assistants who underwent formal university qualifications and specific competencies to undertake the role. The service also encouraged staff to develop their careers through support with undertaking further education and university qualifications, such as advanced practitioner qualifications.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

There was effective daily communication between multidisciplinary teams within the surgical wards and theatres. Staff handover meetings took place during shift changes and 'safety huddles' were carried out on a daily basis in the ward and theatres to ensure all staff had up-to-date information about risks and concerns.

We saw there was effective team working and communication between the theatre teams. Ward staff told us they had a good relationship with consultants and the resident medical officer (RMO). The RMO, pharmacist and physiotherapy staff routinely took part in safety huddle meetings.

Good

Surgery

Staff worked across health care disciplines and with other agencies when required to care for patients. There was routine multidisciplinary working between consultants and external NHS hospital staff and general practitioners (GP's) to discuss the patient's care and treatment. Ward staff also liaised with a number of different services when co-ordinating a patient's discharge. This included hospitals, community services, and social services depending on the area the patient was from.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. There were routine team meetings that involved staff from the different specialties. The patient records we looked at showed there was routine input from nursing and medical staff and allied health professionals. The ward and theatre staff told us they received good support from pharmacists, dietitians, physiotherapists as well as diagnostic support such as for x-rays and scans.

The hospital had commissioning contracts in place and primarily provided surgical procedures for NHS patients from local NHS acute trusts within Greater Manchester. The hospital also had service level agreements in place for a number of services such as pathology, waste disposal, equipment maintenance and equipment sterilisation.

Seven-day services

Key services were available seven days a week to support timely patient care.

Patients were reviewed by consultants daily depending on the care pathway. The resident medical officer (RMO) was on site seven days per week and available on-call during out of hours service. The RMO and ward staff had access to on-call consultant support and had a list of contacts for all the consultants and anaesthetists for each patient. They told us senior medical staff could be easily contacted when needed.

Patients were provided with an emergency contact number so they could contact the service at any time in case of a medical emergency or complication following discharge.

Routine surgery was performed in the theatres during weekdays and on Saturdays (8am-6pm). The theatres did not routinely operate on Sundays.

The inpatient ward accommodated overnight patients seven days per week and staffing levels were suitably maintained during out-of-hours and weekends. The day case unit operated during weekdays and Saturdays and did not routinely open overnight or on Sundays. Theatre lists usually ended by 6pm and the day case unit was staffed until at least 7pm to allow sufficient time for recovery and discharge of day case patients.

The hospital had on-call arrangements in place for key staff groups, including senior managers, pharmacy, physiotherapy and imaging (such as X-rays). Physiotherapy support was available on site during normal hours on weekdays and for a limited number of hours on weekends. The pharmacy was open during routine hours on weekdays. Ward staff had access to emergency medicines during out of hours if required.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Good

Surgery

The service had relevant information promoting healthy lifestyles and support on the surgical ward and day case unit. The ward had a range of information leaflets to provide support and advice for patients around healthier living.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff told us they routinely discussed health promotion and lifestyle choices with patients as these could impact on their ability to receive treatment at the hospital. For example, patients identified as being overweight, patients at high risk due to high alcohol consumption or patients that were smokers were given advice and support, including on how to refer or gain access to external NHS services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff understood how to obtain informed verbal and written consent from patients before providing care or treatment. Records showed 100% of eligible staff across the hospital had completed consent training.

Staff clearly recorded consent in the patients' records. We looked at 6 patient records which showed that patient consent had been obtained and planned care was delivered with their agreement. Written patient consent had been obtained as part of a two-stage consent process.

Staff made sure patients consented to treatment based on all the information available. The consent forms we looked at showed the risks and benefits of the specified surgical procedure were documented and explained to the patient.

A hospital-wide consent audit carried out in July 2023 showed compliance was 96%, which demonstrated high levels of staff compliance with consent processes.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) training was incorporated into the adult safeguarding (level 3) training. The hospital reported there had not been any instances in the past 12 months where a Deprivation of Liberty Safeguards application had been made.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. The nursing and medical staff were trained to carry out mental capacity assessments, in order to determine if a patient had the capacity to make their own decisions. Staff could also seek advice and support from the hospital-wide safeguarding team if needed.

When patients could not give consent, staff told us they made decisions in their best interest, taking into account patients' wishes, culture and traditions. If a patient lacked the capacity to make their own decisions, staff told us they sought consent from an appropriate person that could legally make decisions on the patient's behalf, such as an independent mental capacity advocate (IMCA).

The fees charged for treatments offered to privately funded patients were clearly stated prior to patients undertaking any care and treatment. The hospital had implemented a 14-day cooling off period, in line with Royal College of Surgeons (RCS) guidelines.

Good

Surgery

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw that patients were treated with dignity, compassion and empathy. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Staff followed policy to keep patient care and treatment confidential. We saw nursing and surgical staff spoke with patients in private to maintain confidentiality.

Patients transferred between the ward and theatre areas were given dressing gowns and their dignity was maintained. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Patients said staff treated them well and with kindness. We spoke with 5 patients and a patient's relative during the inspection. They all told us they thought staff were friendly and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained. The comments received included "staff are always nice and friendly", "was well looked after by fantastic staff" and "the nurses were good and always smiling".

Staff sought feedback from patients about the quality of the service provided through feedback surveys that were given to patients after they had undergone care and treatment.

Friends and family test survey results across the hospital for the period between January 2023 and June 2023 showed 92% of patients were satisfied or very satisfied with the care they received at the hospital and 93% of patient reported they were treated with dignity and respect (based on a sample of 614 patients across the hospital). This showed patients were mostly positive about their experience.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We observed staff providing reassurance and comfort to patients.

Good

Surgery

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Patients told us they were supported with their emotional needs and were able to voice any concerns or anxieties. The comments received included "I was reassured by the staff" and "staff knew how to make me feel relaxed and were reassuring".

Patients or their relatives could be referred for access to counselling and psychological support if required.

Patient survey results for January to June 2023 showed 94% of patients responded they could either partially or definitely find someone to talk to about their worries and fears (based on a sample of 614 patients across the hospital). This showed most patients were positive about their experience at the hospital.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff also supported patients to make informed decisions about their care.

The patients we spoke with told us they were kept informed about their treatment and staff were clear at explaining their treatment to them in a way they could understand. They told us the risks and benefits of their procedure were clearly explained to them so they could make an informed decision. The comments received included "all the staff were really professional", "I was well informed all the way through the procedure" and "everything was clearly explained".

Patients gave positive feedback about the service. They also spoke positively about the verbal information and support they received from staff before, during and after their procedure.

Patient survey results for January to June 2023 showed 83% of patients had been partially or fully involved in decisions about their care (based on a sample of 614 patients across the hospital). This showed most patients were positive about their experience.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The service planned and provided services in a way that met the needs of local people. The hospital provided a range of elective inpatient and day case surgical procedures, including general surgery, orthopaedic surgery, ophthalmology, ear, nose and throat (ENT) surgery and bariatric (weight loss) surgery.

Good

Surgery

The surgical services were mainly available for NHS patients as well as for private fee-paying or insured patients over 18 years of age. The service had an inclusion and exclusion criteria and patients admitted for treatment were generally healthy and considered to have a low risk of developing complications during treatment. Patients could be admitted for day case surgery under local or general anaesthetic.

Patients had an initial consultation to determine whether they needed surgery, followed by 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.

Managers planned and organised services, so they met the needs of the local population. There were daily safety huddles meetings so patient flow could be monitored and maintained and to identify and resolve any issues relating to the admission or discharge of patients.

Facilities and premises were appropriate for the services being delivered. The hospital had three laminar flow theatres that could operate up to two sessions per theatre, six days per week. The recovery area could accommodate 4 patients. The inpatient ward had capacity to accommodate 23 patients in individual rooms and accommodated patients 24 hours per day, seven days week. The day case unit consisted of a surgical admissions unit with 3 individual bays and a separate day case ward with capacity to accommodate 8 patients in individual pod bays.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Patients were cared for in individual rooms and there had been no same-sex accommodation breaches reported during the past 12 months.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The service had information leaflets available in languages spoken by the patients and local community. Information leaflets were given to patients prior to undergoing treatment. Information leaflets in different languages or other formats (such as braille, large print or 'easy read' format) could be printed upon request.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed and staff knew how to access them.

Patients with certain conditions were excluded from undergoing treatment at the service. For example, patients with complex pre-existing medical conditions or a body mass index (BMI) of greater than 45. Patients undergoing bariatric (weight loss) surgery could be admitted for treatment with a BMI up to 55 (female patients) and up to 50 for male patients. Services were only available to patients over 18 years of age.

The NHS commissioning contract outlined the processes for equal opportunities including how the service ensured they did not discriminate, including on the grounds of protected characteristics under the Equality Act, when making care and treatment decisions. Staff also received equality and diversity training as part of their mandatory training.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff completed training in the Mental Capacity Act, autism awareness and training for dementia awareness.

Good

Surgery

The initial consultations and pre-operative assessments identified patients living with dementia or a learning disability and this allowed the staff to decide whether they could treat these patients and put plans in place to provide safe care and treatment. Staff told us they allowed patients' relatives or carers to accompany patients if this was seen to be in their best interest or there were specific circumstances, such as if the patient was living with learning disabilities.

Staff we spoke with were able to give examples of reasonable adjustments made when carrying out procedures for patients with specific needs, such as adjusting theatre lists to accommodate patients' needs or preferences. The services were accessible for patients with a wheelchair and other facilities were available for patients living with a disability (such as hearing loops).

The ward was designed to meet the needs of patients living with dementia. We saw dementia-friendly pictorial signage was in place for rooms and bathrooms and there was a dementia-friendly clock in the common room.

Access and flow

People could access the service when they needed it and received the right care promptly. Patient length of stay and discharge processes were effectively planned and organised. The surgical services did not achieve national standards for waiting times from referral to treatment. However, the service had actions to improve this.

Managers monitored waiting times and made sure patients could access services. Patients undergoing private treatment did not experience significant delays or waiting times for their treatment. The hospital provided elective surgery across a number of surgical specialties for NHS patients on the referral to treatment waiting lists, under commissioning arrangements mainly from the Greater Manchester area.

There was a total of 8,442 NHS patients across all specialties on the referral to treatment (RTT) pathway in October 2023. This included 4,383 patients on pathway waiting less than 18 weeks (52%), 2,896 patients waiting between 18 and 36 weeks (34%), 804 patients waiting between 36 and 52 weeks (10%) and 359 patients waiting between 52 and 78 weeks (4%). There were no patients on the waiting list that had waited longer than 78 weeks.

The proportion of patients waiting less than 18 weeks from referral to treatment ranged between 52% and 66% during the period between November 2022 and October 2023. During this period, the total number of patients waiting between 78 and 104 had reduced from 36 to zero patients and those waiting between 52 and 78 weeks had reduced from 436 to 359 patients. However, the total number of patients waiting less than 18 weeks had increased from 3,365 patients in November 2022 to 4,383 patients in October 2023.

Patients on the list were a combination of new referrals through the NHS e-referral service (ERS) and patients already on NHS waiting lists that had been referred to the service for treatment as part of the commissioning arrangements to support local NHS trust waiting lists.

The operations manager told us they carried out weekly monitoring of referral to treatment performance for NHS patients. To maintain patient safety, available capacity was allocated based on clinical need and patients were managed in order of clinical priority. Patients on the waiting list for extended periods of time were reviewed by a clinician to identify any changes to their clinical needs and were prioritised for surgery if required.

Good

Surgery

Managers and staff worked to make sure patients did not stay longer than they needed to. The majority of patients attended the hospital for day case surgery. The average length of stay on the inpatient ward ranged between 1.8 and 2.1 days over the last 12 months. The senior managers told us they planned to implement enhanced recovery pathways for certain specialties (such as orthopaedics and bariatric surgery) during January 2024 and this would further reduce overall patient length of stay.

During the inspection, we did not observe any significant concerns relating to patient access and flow. The environment in the wards and theatres appeared calm and relaxed and we found a number of beds were empty during the days of the inspection. Patient admissions were staggered throughout the day so that patients did not have to wait for a long period of time once admitted to the ward. The patients we spoke with told us they had not experienced any delays on the day of surgery and had been promptly admitted to the ward and theatres on the day of surgery.

Managers and staff worked to make sure that they started discharge planning as early as possible. Discharge planning was covered during pre-assessment to determine how many days patients would need on the ward as well as ascertaining whether patients were likely to require additional support at home when they were discharged.

The shift coordinator on the ward was responsible for carrying out all patient discharges and liaised with the resident medical officer and pharmacists so that patients were discharged in a prompt and timely manner.

Patient records showed staff had completed a discharge checklist that covered areas such as discharge medicines prescribed and communication to the patient and other healthcare professionals, such as GP's, to ensure patients were discharged in a planned and organised manner.

Managers worked to keep the number of cancelled operations to a minimum. There had been 2,741 surgical procedures cancelled between November 2022 and October 2023. This included 2,741 (85%) patient initiated cancellations. The main reasons for the remaining non-patient initiated cancellations were due to consultant request (95 cancellations), theatre session cancelled (65 cancellations) and consultant anaesthetist unavailable (64 cancellations).

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible. The hospital reported there had been 19 instances where cancelled patients had not been given an appointment within 28 days of the cancellation between November 2022 and October 2023. The main reasons were patient choice (11 instances) and consultant unavailability (5 instances).

Senior managers monitored information around theatres efficiency to identify improvements to the services. Staff told us they did not routinely experience late starts or overruns unless there had been a patient complication during surgery. The surgical services had commenced a 'golden patient' pilot project over the past 2 months. This involved starting the theatre list with a generally fit, low acuity patient to enable a prompt start. Staff told us the 'golden patient' pilot had led to improvements in theatre list late starts and overruns.

There had been 103 instances in the past 12 months where surgical patients did not attend their appointment or surgical procedure. Where patients did not attend their appointment, staff contacted them to determine the reason they did not attend and to reschedule a new appointment date.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Good

Surgery

Patients, relatives and carers knew how to complain or raise concerns. The patients we spoke with told us they had been given information leaflets detailing how to complain or raise concerns prior to undertaking surgery.

The management of patient complaints policy provided guidance on how to manage and respond to complaints about the service. Staff understood the policy on complaints and knew how to handle them.

The complaints policy stated that patient complaints would be acknowledged within 3 working days and responded to within 20 working days for routine complaints. Staff were required to send holding letters to patients if a complaint required further investigation and could not be responded to within the timelines specified in the complaints policy.

Where patients were not satisfied with the response to their complaint, they were given information on how to escalate their concerns within the service (at hospital and corporate provider level) or to external organisations such as the Parliamentary and Health Service Ombudsman (for NHS patients) and the Independent Sector Complaints Adjudication Service (ISCAS) for private funded patients.

From December 2022 to November 2023 there were a total of 20 complaints across the hospital, including 15 complaints relating to the surgical services. The most frequent reason for complaints was in relation to general care / treatment and staff communication. The hospital reported 14 of the 15 complaints about the surgical services had been responded to and closed within 20 days during this period. The remaining complaint had been closed but the response was delayed due to staff unavailability.

Managers shared feedback from complaints with staff and learning was used to improve the service, as part of routine clinical governance meetings and medical advisory committee meetings as well as routine ward and theatre staff meetings to aid future learning. We saw evidence of this in the meeting minutes we looked at.

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The overall lead for the hospital was the hospital director, who was also the registered manager for the service. The hospital director was supported by the head of clinical services, the finance manager and the operations manager.

The hospital also had a governance manager, a facilities manager and an infection prevention and control lead in place.

The ward manager and the theatre manager were responsible for the day to day management of the ward and theatre areas. There was a senior nurse in charge on each shift on the ward, who acted as a coordinator and oversaw patient discharges. The consultant surgeons and anaesthetists had clinical responsibility for the patients they treated. The medical staff were overseen by the medical advisory committee (MAC).

Good

Surgery

The senior leadership team, ward and theatre managers had the relevant skills and abilities to manage the surgical services effectively. They understood the risks to the services and had clear oversight on patient safety, governance and performance issues through daily involvement and quality monitoring.

A daily safety and business huddle took place at the start of each day. This was led by the hospital director and involved the senior leadership team and heads of department. There were regular safety huddles and team briefings in the ward and theatre areas so that staff received all relevant information.

The nursing, support and medical staff we spoke with told us they understood the reporting structures clearly and described their line managers as approachable, visible and who provided good support.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The hospital incorporated the corporate vision and values called the 'Ramsay way'. This was based on 3 values relating to building strong relationships, aim to constantly improve and seek to grow sustainably.

The hospital had 3 clinical priorities for 2023/24; to improve patient experience at Oaklands, implementation of 24 hrs arthroplasty service and to review the feasibility of internal and external accreditation status.

The hospital outlined 5 strategic objectives for 2023/24. These were based on patient safety, engagement, development and retention of staff, improvement to clinical service delivery and financial performance.

Performance against the clinical priorities and strategic objectives was monitored as part of routine monthly senior leadership team meetings.

The strategic objectives were clearly displayed on notice boards across the ward, day case and theatre areas. They had been cascaded to staff across the services and the staff we spoke with had a good understanding of these. Objectives were also incorporated into individual staff appraisals.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The staff we spoke with were highly motivated, patient-focussed and spoke positively about working in the surgical services. They told us there was a friendly and open culture and that departmental and senior hospital managers were visible and approachable.

The ward staff, theatre staff and consultants we spoke with told us they received regular feedback to aid future learning and that they were supported with their training needs by their line managers.

Staff felt confident to raise issues with line managers and felt managers responded positively when concerns were shared. The service had appointed an independent freedom to speak up guardian

Good

Surgery

All the staff we spoke with were aware of the whistleblowing policy and understood how to contact the freedom to speak up guardian if needed. There had not been any significant whistle blower concerns raised by the service or received by the Care Quality Commission during the past 12 months.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were clear governance structures in place that provided assurance of oversight and performance against safety measures. There were a number of groups and committees (such as the health and safety, infection prevention and control champions group, medicines management committee and clinical governance) in place that held meetings either monthly or every three months and reported to the senior leadership team.

The medical advisory committee (MAC) held meetings every three months led by the MAC chair. The MAC meetings were attended by the senior leadership team and surgical specialty lead consultants. Meeting minutes between May 2023 and September 2023 showed the MAC undertook reviews of new and updated guidance, consultants' performance, practicing privileges reviews as well as a review of governance and key risks.

The clinical governance meetings were held monthly and were attended by the senior managers and departmental leads. Meeting minutes for October 2023 and November 2023 showed discussions took place around performance and quality, governance, incidents, complaints and audit performance.

The senior leadership team (SLT) held meetings on a monthly basis. The hospital director also chaired monthly integrated governance meeting, that were attended by senior managers across the hospital. Meeting minutes between September 2023 and November 2023 showed discussions took place around governance, risks and performance. The SLT and integrated governance meetings also reviewed minutes and reports from departmental leads and the various committee meetings held across the hospital.

Meeting minutes also showed governance and quality reports with detailed information and data around incidents, complaints, audit results, staffing information, governance and risks were produced to inform the clinical governance, MAC and SMT meetings.

The hospital director and senior managers held daily and weekly informal meetings to discuss day to day issues. There were daily huddles held in the ward and theatre areas and a hospital-wide huddle held daily to manage patient risks and cascade governance information to staff.

The ward and theatre teams held monthly staff meetings. Meeting minutes from September 2023 showed that discussions took place around incidents, workforce, performance and governance issues and key risks, along with shared learning.

Meeting minutes showed action plans were in place and these were followed up at subsequent meetings.

There was regular communication and oversight from the corporate provider. The senior leadership team and departmental leads routinely reported governance, performance and risks to the corporate provider and performance across key indicators around patient safety, staffing and performance was collated and benchmarked against the provider's other hospital's nationally. The performance dashboard showed the hospital was in line with most of the corporate provider's benchmarks for key performance indicators.

The senior managers and departmental managers also participated in regular peer meetings to share learning and benchmarking with the provider's other hospitals across the region and nationally.

The hospital submitted a formal report detailing performance against key indicators for NHS patients to local service commissioners every 3 months. The Salford integrated care partnership quality assurance visit report from September 2023 was mostly positive and did not identify any concerns around patient safety or performance in relation to NHS commissioned services. The report identified one minor recommendation around improvements to information in discharge leaflets.

Practising priveleges were routinely reviewed and authorised by the hospital director, head of clinical services and the MAC chair and were also ratified at the medical advisory committee.

We spoke with two surgical consultants and the MAC chair, who told us practising privileges were reviewed annually and they were required to submit updated appraisals, GMC registration information and indemnity insurance information to the hospital on an annual basis.

The hospital reported there were no outstanding queries relating to practising privileges. We looked at the records for three consultants who worked across both the surgical and outpatient services. These contained up to date appraisal records, General Medical Council (GMC) revalidation, indemnity certificates and Disclosure and Barring Service (DBS) checks. The General Medical Council (GMC) registration showed the consultants were listed on the specialty register.

We looked at the recruitment records for the MAC chair and the head of clinical services. We also looked at the recruitment files for 3 consultants (who worked across both the surgical and outpatient services), a surgical first assistant and 4 nursing and healthcare staff from the ward and theatre.

We found evidence that suitable checks had been carried out prior to commencement of employment in the files we looked at. This included identification checks, proof of qualifications and mandatory training, at least two employment references, Disclosure and Barring Service (DBS) checks and professional body registrations and revalidations.

The hospital reported there were no outstanding queries relating to practising privileges. The 3 consultants' files we looked at showed up to date appraisals and indemnity certificates and the consultants were listed on the GMC specialist register relevant to their specialty area.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The key risks relating to the surgical services were recorded on departmental risk registers that were incorporated into the hospital wide risk register. The risk registers showed that key risks were identified and control measures were put in place to mitigate risks. Risks had a review date and an accountable staff member (such as the ward manager or theatre manager) responsible for managing that risk.

Staff were aware of how to record and escalate key risks on the risk register. A risk scoring system was used to identify and escalate key risks to the hospital risk register.

Good

Surgery

Staff were supported by the governance manager to review open risks and identify mitigations / controls to reduce or eliminate risks. Key risks and risk register entries were reviewed at monthly departmental meetings as well as routine clinical governance, medical advisory committee and senior leadership team meetings.

Routine staff meetings took place to discuss day-to-day issues and to share information on complaints, incidents and audit results.

We saw that routine audit and monitoring of key processes took place to monitor performance against patient safety standards and organisational objectives. There was a structured programme of audit covering key processes such as infection control, patient records and medicines management. Audit participation and performance was collated and benchmarked against the provider's other hospital's nationally.

Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through routine team meetings, safety huddles, performance dashboards and newsletters.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Performance information was collected and analysed by the surgical services and was used to develop and support the delivery of services. Staff used electronic systems for the real-time planning and monitoring patient flow and theatre utilisation and cancellations. The surgical services had performance dashboards in place that were updated monthly and provided a detailed overview of patient safety, performance and staffing indicators. The clinical dashboards included comparative data over time and comparative data from the provider's other hospitals nationally.

There were systems in place for the safe storage, circulation and management of electronic and paper-based records such as patient records, audit records and meeting minutes. Patient records were accessible for staff and could be easily retrieved. Electronic records were stored on computers with controlled access.

Staff completed data security awareness training as part of their mandatory training. Training compliance across the surgical services was 94%, showing most staff across the surgical services had completed this training.

The operations manager was the information governance lead for the service and was responsible for reporting to the Information Commissioner's Office (ICO). There had been no ICO reportable data breaches during the past 12 months.

The ward and theatre areas had a number of notice boards that displayed information such as audit and survey results, safety bulletins, meeting minutes, quality and performance dashboards, patient safety and infection control information.

Staff could access information such as policies and procedures in paper and electronic format. The policies we looked at were version-controlled, up to date and had periodic review dates.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Good

Surgery

Staff told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings and took part in daily huddles across the areas we inspected. The service also engaged with staff through newsletters, briefs and through other general information and correspondence that was displayed on notice boards and in staff rooms.

The service carried out an annual staff survey to gain feedback from staff about their experiences. The hospital-wide staff survey (2023) showed 67% of staff felt engaged with the service. This had improved from 50% in the 2022 staff survey. The 2023 staff survey also showed most staff responses were positive in relation to survey questions about well-being (72%), inclusion (69%) and expectation versus experience (76%). The 2023 staff survey had recently been completed and the senior managers were in the process of developing an action plan in response to the 2023 staff survey findings.

The hospital routinely engaged with patients and their relatives to gain feedback from them. This was done informally and formally through participation in patient surveys. Patient compliments were also collated on a monthly basis and displayed on notice boards in the areas we inspected.

Friends and family test survey results across the hospital for the period between January 2023 and June 2023 showed most patients were positive about the care and treatment they received.

The hospital had submitted additional friends and family data for October 2023 and November 2023, at departmental level (including for surgery, outpatients and radiology services). We did not report on this because the departmental-level survey response rates were low (range between 1% and 3%), and not a sufficiently representative sample size.

There was an action plan in place to improve friends and family survey response rates to the minimum corporate provider target of 15%. Actions taken to improve response rates included patient information booklets placed in all patient rooms with survey links, posters displaying QR codes and survey links added to the text message reminders.

The hospital utilised the net promoter score (NPS), which assesses the likelihood of a patient to recommend their healthcare provider on a scale of 0-10. The NPS data during the period between January and June 2023 showed the proportion of patients at this hospital who gave a rating of 9 or 10 for indicators relating to kindness and compassion, information, communication, pain and nausea management, confidence and consistency in care and customer service ranged between 80% and 93% (sample size between 50-100 responses). This showed the majority of patients experienced positive care and treatment during their hospital stay.

During January to June 2023 the hospital achieved an overall NPS score of 74, which was below the corporate provider target of 86. There was an action plan in place to improve compliance scores and progress was monitored as part of monthly clinical governance meetings.

The hospital also collated patient experience feedback through the Private Healthcare Information Network (PHIN). Data for the period between October and November 2023 showed the hospital achieved patient experience scores above 90% (based on 489 responses), indicating most patients were positive about their experience during their hospital stay.

Staff across the hospital services also held regular public engagement events and educational workshops attended by members of the general public and local healthcare representatives, such as primary care network education talks and workshops relating to joint care and orthopaedic and general surgical procedures.

Good

Surgery

We saw evidence there was routine formal and informal engagement and collaborative working with stakeholders, commissioners, other healthcare providers which the hospital worked with under service level agreements as well as routine engagement with the corporate provider and the provider's other hospitals.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Staff told us the service had a positive culture that was focussed on learning and improvement. We saw evidence of learning and improvement resulting from findings from audit results, incidents and complaints and shared learning was cascaded to staff to improve the service.

A number of improvements had been implemented or were planned as part of the hospital's plan to improve patient experience.

The hospital had ongoing refurbishment plans to expand and improve the main reception areas in order to improve access and flow and overall patient experience.

The hospital had recently trialled the 'Sip Til Send' policy for patients undergoing bariatric (weight loss) surgery and this had led to improved patient outcomes. The services planned to expand the 'Sip Til Send' policy across other surgical specialities, such as orthopaedics and general surgery during 2024.

The surgical services planned to implement an enhanced recovery after surgery (ERAS) service to reduce length of stay and improve patient experience following knee and hip arthroplasty by January 2024. Enhanced recovery is an evidence-based approach to delivering care in a way that promotes a better surgical journey for the patient and delivers a quicker recovery.

The ward staff also participated in sleep studies clinical trial in collaboration with a local NHS trust.

Good

Diagnostic imaging

Safe	Good
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Good

Is the service safe?

Good

We previously rated outpatients and diagnostic imaging as one core service. We now rate them separately. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

The service had 100% completion of all mandatory training by eligible staff for the year 2023 to 2024. The target was 95%.

Radiologists completed mandatory training with their substantive NHS employer and provided annual confirmation of completion of this training to the hospital in line with the practising privileges policy.

For our detailed findings on mandatory training, please see the safe section in the surgery report.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse.

Good

Diagnostic imaging

All clinically registered staff in the department were trained to level three in children and adult safeguarding with all other staff trained to level two. Levels one and two training were undertaken annually. Training included female genital mutilation (FGM) and child sexual exploitation. All eligible staff in the department were trained in levels 1 and 2 safeguarding adults and safeguarding children. All eligible clinical staff in the department had undertaken Adult Safeguarding Level 3 training.

There was no level four trained person in the diagnostic imaging department but there was a level four trained safeguarding lead in the hospital who was easily accessible, and staff knew how to contact them.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the department although patients were asked not to bring children to the hospital unless a baby that would require feeding.

For our detailed findings on safeguarding and the hospital safeguarding lead, please see the safe section in the surgery report.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. The waiting areas, examination room, diagnostic areas and changing rooms were all visibly clean and we saw completed cleaning rotas.

Staff followed infection control principles including the use of personal protective equipment (PPE). The department provided staff with personal protective equipment (PPE) such as gloves and aprons. We observed staff wore PPE where necessary.

The service completed monthly hand hygiene audits. The audit results showed that from May to October 2023, compliance with hand hygiene in the radiology department was 100% in all months.

Staff cleaned equipment after patient contact. Radiographers completed hand hygiene before seeing a patient, wore suitable personal protective equipment and cleaned diagnostic equipment after each used. Staff were observed to be bare below the elbows.

The hospital carried out a 50 steps cleaning audit monthly. Compliance with this audit for the radiology department from May to October 2023 was between 93% and 99%.

The diagnostic department had not reported any hospital acquired infections in the previous year.

Each clinical area had a foot operated clinical waste bin, sharps bins were present which were clean, not over filled and secure.

Ultrasound probes were cleaned in line with best practice, the cleaning process was documented and audited. Staff had received training in using the specialist gels to clean the ultrasound probes.

Hand sanitiser was available for staff and patients throughout the department, staff were observed using this both before and after patient contact.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service had enough suitable equipment to help them to safely care for patients. The service had suitable facilities to meet the needs of patients' families. The diagnostic department was on the first floor, this included an ultrasound scanning room (and a clinic room that could be used as a second ultrasound room during busy clinics or during the gynaecology outpatient clinic), a plain x-ray room and a bone density scan (DEXA) room. A mobile computerised tomography (CT) scanner attended the hospital once a week and a mobile magnetic resonance imaging (MRI) scanner 5 times a week. They were located in the car park.

The radiology department was small but the provider had plans to expand the size of the department which were in progress. There was an identified need to refurbish and expand the size of the x-ray room and another ultrasound room. They were also looking at the feasibility of having a static MRI scanner.

There was one changing cubicle in the waiting area, however, this was only a few feet from where patients were sitting in the waiting room and would not afford full privacy and dignity. The cubicle was not being used for patients who needed to change but was used for weighing and taking the height of patients. Patients who needed to change, did so within the room where their scan was taking place.

The waiting area was small but had adequate seating. There was only one priority seat for patients who had recently had surgery that was raised and had a higher back but it was unclear what would happen if two or more people with mobility issues required a higher seat.

Staff carried out daily safety checks of specialist equipment. Equipment in the department was clean and servicing contracts were in place. We saw that equipment had been serviced and the service record was in date. However, we saw that the mattress in the DEXA scanning room was damaged but a new one was on order. The DEXA machine had broken down on the day of our inspection, despite a recent service but an engineer attended immediately to enable it to be fixed at the earliest opportunity. The manager also told us that the X-ray machine would also need replacing within the next two years.

There was a backup portable x-ray machine for use on the ward but this was rarely used as most patients were able to be brought to the x-ray room in their bed where a lineal x-ray could be performed safely.

Lead aprons were used when staff were carrying out x-rays, these aprons were used to protect against radiation exposure. Staff used body and thyroid shield lead aprons. The aprons were well maintained and in good condition. We saw evidence that the aprons were scanned annually to check that they were undamaged and still offered full protection.

Local rules for radiation were displayed in the department and had been signed by all appropriate members of staff.

There was clear signage and warning lights outside controlled areas where radiation was being used, which told both staff and patients not to enter when the sign was illuminated.

Staff had access to alarms in the event of an emergency.

There were pause and check signs in the control areas of each diagnostic room which reminded staff to check patient identity, correct area for scan, radiation dose and clinical justification. We observed staff checking the identity of the patient by asking full name, date of birth, address, and the areas to be scanned.

Staff disposed of clinical waste safely.

Emergency resuscitation equipment was available for the service on the first floor corridor. The diagnostic imaging department shared a resuscitation trolley with the outpatient department. The resuscitation trolley was clean, and contents were secured with a tag. The trolley was checked daily by ward staff and monthly by an external company.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Staff responded promptly to any sudden deterioration in a patient's health. There were emergency call bells throughout the hospital. The department had a policy for recognising the deteriorating patient. This included escalation processes. Staff could give examples of when they had used the escalation process, this included calling the resuscitation team or resident medical officer (RMO) beginning observations and getting the resuscitation trolley. The RMO, together with the responsible consultant, would then decide to manage the patient at the hospital or authorise emergency transfer to a local NHS Trust.

A resuscitation team in the hospital was named every morning. This included a team leader, airway and compressions clinicians and a runner. Details of the team were displayed in the department at the start of each day.

There were procedures in place for staff in the mobile CT or MRI units to call for the resuscitation team in the event of an emergency by use of walkie talkies to contact staff on the main hospital reception with access to the emergency call button.

Staff completed risk assessments for each patient on arrival. We observed reception staff confirming patient identity when they arrived at the department, this was then checked again by radiographers before patients were scanned. Safety questionnaires were completed prior to imaging procedures taking place and patient allergies were noted on their electronic record.

Comprehensive safety questionnaires included details of any magnetic devices or implants; details of any other metal in the body; allergies and risk of pregnancy. Posters were located in the department reminding staff and patients about the need to discuss the possibility of pregnancy or risks if they already had a confirmed pregnancy.

For patients undergoing treatments using contrast agents, there was a separate safety questionnaire that also asked whether the patient had kidney function problems; were awaiting or had had a liver transplant and whether they had previously had a reaction to a contrast agent.

Good

Diagnostic imaging

Staff knew about and dealt with any specific risk issues and shared key information to keep patients safe when handing over their care to others. If the radiographer noted any unexpected or significant findings from image reports these would be escalated to the treating consultant. Staff would contact the referrer by telephone and follow this up with an urgent report.

Shift changes and handovers included all necessary key information to keep patients safe. A staff huddle was held every morning, during which, any patient safety information and learning was relayed to staff.

The service had 3 radiation protection supervisors so there was one on site at all times. There was a service level agreement with an external company in place for a radiation protection advisor.

All staff were required to complete basic life support as part of their mandatory training. Clinical staff had undertaken immediate life support training.

There was a World Health Organisation (WHO) checklist in place in ultrasound and a WHO surgical safety checklist for non-general anaesthetic procedures.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough staff to keep patients safe. The service included radiographers, and non-clinical administration staff. The manager adjusted staffing levels daily according to the number of clinics running and the number of patients attending. Bank staff were used to cover additional shifts if required but the service had low rates of bank nurse usage.

The service had no vacancies. There was a radiology imaging manager; a senior radiographer; 4 radiographers; 3 radiography assistants; a receptionist and an administrative assistant. The service was overstaffed by 1 radiographer but they were due to leave the service and a new radiographer had already been recruited.

Managers made sure bank and agency staff had a full induction and understood the service before starting their shift. The induction programme included training on how to use the diagnostic imaging equipment.

The service had a low turnover of staff.

The service had enough medical staff to keep patients safe. There were 7 or 8 reporting radiologists supporting the service who were employed under practising privileges.

For details about how the hospital checked and employed staff under practising privileges, please see the safe section of the surgery report.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Patient notes were in the forms of electronic and paper, a paperlite system. Records were stored securely.

Good

Diagnostic imaging

We reviewed 7 patient records, all were clearly recorded with the required information for example, radiation doses, personal details, consent and confirmation that results were shared with GP, referring consultant and the patient.

Radiologists reported on images on shared electronic systems and results were securely sent to referring clinicians. The department used electronic systems such as picture archiving communication services (PACS) and radiology information software (RIS) for the storage and transfer of images. Images could be sent securely to other hospital sites if the radiologist responsible for the patients' care needed to review the image.

The electronic imaging systems used were password protected and all radiographic staff and radiologists had personal log in details.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when prescribing and administering medicines. Medicines used were local anaesthetic, contrast agents and cleansing agents. The department did not use any controlled drugs. Staff followed current national guidance to check patients had the correct medicines.

All medicines were stored safely in locked cupboards.

We found the fridge for medicines was in good working order. Room and fridge temperatures were recorded daily and were within a safe range.

In the event of an emergency, the department had an adult anaphylaxis box which was in date, it was secured with a number tag by the pharmacy.

For details about pharmacy stocks and controls please see the surgery report.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff were aware of how to raise concerns, report incidents and near misses in line with the hospital policy. Staff reported incidents via an electronic system. The department was proactive in reporting no-harm incidents and near-misses as well as incidents where harm may have occurred.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers shared learning with their staff about never events that happened elsewhere. There had been no never events and no serious incidents reported in the department in the previous 12 months though learning from never events and serious incidents in other Ramsay hospitals were shared at staff meetings and in safety huddles.

Good

Diagnostic imaging

Staff understood the term duty of candour, which was covered in a mandatory training module for staff to complete. There was a duty of candour policy in place and staff were able to tell us what their responsibility was when something had gone wrong.

The service outlined the process of reporting a radiation incident in their radiation local rules.

Learning from incidents was shared in staff meetings. There was a monthly update of the hospital's incidents and lessons that had been learnt.

Managers debriefed and supported staff after any serious incident.

From December 2022 to November 2023 the service had reported 32 incidents, all of which were no or low harm incidents or near misses.

Is the service effective?

Inspected but not rated

We inspected the effective domain but we do not rate this for diagnostic imaging services.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Guidance from the Royal College of Radiologists, the College of Radiographers and the National Institute of Health and Care Excellence (NICE) were available to staff via the intranet.

The hospital's overarching policies were produced and reviewed centrally by the hospital group. Staff were able to access all policies on the hospital's computer system. The manager also displayed or stored some of these in the department office so that staff could access information quickly.

The manager told us that, on occasion, they would be asked to review proposed policies, for example, a new policy on DEXA scans was sent to them for review before being finalised because only 3 Ramsay Hospital Group sites carry out DEXA scans. As well as asking the DEXA radiographers to review the proposed policy and offer opinions, the service also had it reviewed by the lead radiologist for nuclear medicine at the nearby NHS trust.

The service provided care and treatment based on national guidance including the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). Policies were aligned with and referenced the Ionising Radiation Regulations 2017. The Ionising Radiation Regulations 2017 are regulations concerned with the protection against exposure to ionising radiation as a result of work activities. The radiation safety policy and local rules for radiation safety were up to date and were available to staff both as a paper copy or electronically.

Good

Diagnostic imaging

We observed that all local rules were signed and dated by staff as being understood, within the twelve months prior to our inspection. Imaging risk assessments were completed, and we saw that pathways were in place for certain conditions. Local rules were in each diagnostic room and had been signed by each member of staff. Managers checked that staff followed these.

The diagnostic department used the World Health Organisation (WHO) surgical safety checklist when carrying out invasive procedures.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in a national clinical audit for patients from a private healthcare provider so that the provider could ascertain that services provided remained valid to patient needs. Managers used information from the audits to improve care and treatment.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time and used the results to improve patients' outcomes. The hospital had a clinical audit system. The department carried out local audits, such as WHO checklist audits; imaging documentation audits; post-examination documentation and point of care clinical audits.

There were regular performance reports based on audits and action plans were produced for any audits that were less than 100% compliant.

Managers shared and made sure staff understood information from the audits.

The diagnostic department used pathways and protocols for procedures that were evidence based and available on the intranet for staff.

For further information on audits and patient outcomes, please see the surgery report.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. Staff in the radiology department also had a role specific induction which covered areas such as clinical policies and procedures, radiation local rules and Ionising Radiation (Medical Exposure) Regulations (IR(MER). Diagnostic radiographers had a comprehensive training in all relevant diagnostic procedures in the department and there was a competency-based assessment in place.

New staff underwent a supernumerary period of 6 to 8 weeks, dependent on experience and there were induction checklists in place. Staff also completed a preceptorship booklet to reflect on their initial induction and training.

The department also delivered radiation protection training to staff across the hospital as part of their induction.

Good

Diagnostic imaging

Managers supported staff to develop through yearly, constructive appraisals of their work. We saw that all eligible staff had received an annual appraisal.

Managers supported staff to develop through regular, constructive clinical supervision of their work. A competency framework was in place. This meant staff undertook training and were assessed in practice; the manager then verified that the member of staff was competent. All staff were expected to meet these competencies. Diagnostic staff had both files which included training certificates and competencies they had achieved.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. There were opportunities for continual professional development which was a requirement of their registration with the Health and Care Professions Council (HCPC).

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Staff were encouraged to upskill and learn different specialisms, such as DEXA scanning.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Patients could see all the health professionals involved in their care at one-stop clinics, so, for example, following an outpatient appointment, an x-ray could be undertaken or bloods taken.

Staff worked across health care disciplines and with other providers when required to care for patients. Relevant information was shared with the patient's GP or NHS acute hospital where necessary.

We observed staff working well together as a team, the department had a positive and respectful atmosphere.

Staff told us they believed there was very good lines of communication within the department. Important messages were shared each morning at a hospital wide multidisciplinary management meeting.

Seven-day services

Key services were available to support timely patient care.

Staff could call for support from doctors and other disciplines.

The department ran services throughout the week, including evenings and some weekend clinics, to meet demand.

Good

Diagnostic imaging

There was an on-call service out of hours in the event that any radiography was required urgently by the hospital ward.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had some information promoting healthy lifestyles and support in patient areas, such as smoking cessation and advice about the menopause.

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care and knew how to access the policy on Mental Capacity Act.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The process for patient consent was detailed in a corporate consent policy. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We observed staff obtaining verbal consent from patients before carrying out a scan, staff asked patients if they knew why they were having the scan, explained the procedure and confirmed with the patient if they were happy to have the scan.

Staff made sure patients consented to treatment based on all the information available.

When patients could not give consent, staff followed policy to ensure decisions were made in their best interest, taking into account patients' wishes, culture and traditions. Staff were aware of the hospital's mental capacity policy and could explain what would happen if a person did not have the capacity to consent to any imaging procedure. They told us they would not continue with the scan but would seek further guidance from the referring doctor.

Staff told us that patients who lacked full capacity were generally accompanied by a relative or carer.

Staff clearly recorded consent in the patients' records. We reviewed 7 sets of patient notes and saw that these all had consent signed by the patient.

Staff received and kept up to date with training in the Mental Capacity Act.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005 and they knew who to contact for advice.

For patients who could not speak English there was an interpreting service available that could be used to help with the consent process.

Good

Diagnostic imaging

Is the service caring?

Good

We previously rated outpatients and diagnostic imaging as one core service. We now rate them separately. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff introduced themselves to patients and took time to ask how they were feeling. Staff asked patients how they felt about the imaging procedure and if they had any questions.

Staff clearly explained the diagnostic procedure and the time it would take to the patient. We witnessed staff interacting with patients before and throughout their procedure. Staff gave patients positive feedback during the imaging procedure where appropriate and continued to ask how the patient was doing. Patients were reminded to tell staff if they wanted the procedure to stop at any time.

Patients said staff treated them well and with kindness.

Reception staff were kind, sensitive and caring when speaking to patients.

Staff followed policy to keep patient care and treatment confidential. Staff maintained privacy and dignity by ensuring blinds and doors and modesty curtains were closed when patients entered the room.

Staff understood and respected the individual needs of each patient.

Chaperones were available to support patients during procedures if needed.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Good

Diagnostic imaging

Staff maintained constant interaction with patients throughout their scans, they talked patients through the procedure and went at a pace that suited the patient. Patients who may need more time for scans due to complexities such as mobility issues or pain were highlighted during the booking process so that additional time could be added to their appointment.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff asked patients if they felt they would be able to maintain a certain position for the length of time needed while undergoing a scan.

Patients told us that staff were very reassuring. Patients told us that everything had been explained to them very well and they were well informed about how long they would have to wait for any results.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff could explain what they would do if they recognised a patient who may need additional support to understand and be involved in their care.

Staff talked with patients, families and carers in a way they could understand.

Staff supported patients to make informed decisions about their care.

There was a range of imaging and diagnostic information on the services website which was available to patients. This information explained why you might need an x ray, who will do it and the procedure.

Patients and their families could give feedback on the service and their treatment in a number of ways and staff supported them to do this. There were posters in the waiting area which highlighted to patients how to give feedback.

Patients generally gave positive feedback about the service.

Examples of positive comments received were “very professional and understanding. Both the nurse and doctor put me at ease. Lovely friendly professionals.” and “ultrasound went really smoothly. Staff really helpful and sensitive.”

For detailed information about patient feedback received, please see the surgery report.

Feedback comments were passed on to staff to reassure them that the patients had a good experience. Negative comments were analysed and used to make improvements to the department.

For details of the Private Healthcare Information Network (PHIN) outcomes on care for Oaklands Hospital, please refer to the surgery report.

Good

Diagnostic imaging

Is the service responsive?

Good

We previously rated outpatients and diagnostic imaging as one core service. We now rate them separately. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The department offered a range of diagnostic services to both self-paying, privately insured and NHS patients.

The service minimised the number of times patients needed to attend the hospital by ensuring patients had access to the required staff and tests on one occasion.

Patients attending outpatient appointments who required an x-ray were sent to the department where they were processed as a priority.

Managers ensured that patients who did not attend appointments were contacted. The department monitored patients who did not attend for treatment, the levels were low. Patients would be contacted and asked if they wanted to book a new appointment.

The department offered late evening and weekend appointments to accommodate for patients who could not make weekday appointments, for patients who needed an urgent scan the best effort was made to give the patient a scan as soon as possible.

The radiology department was accessible to wheelchair users or other mobility issues via lift access.

For information about the suitability of the premises, please refer to the surgery report.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Patients with complex needs were provided with increased appointment times to allow staff time to provide additional support and these could be at the beginning or end of a clinic.

Staff gave examples of patients with learning disabilities or living with dementia who had attended for diagnostic imaging. Patients had been accompanied by carers for support.

The department was not designed to meet the need of patients living with dementia. There were no dementia friendly or learning disability adjustments in the department, such as signage or clocks as were evident in other areas of the hospital.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Interpreter and translation services were available.

For further information about meeting people's individual needs, please see the surgery report.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times for treatment were in line with national standards.

Managers monitored waiting times and made sure most patients could access services when needed and received treatment within agreed timeframes and national targets. Patient appointments were booked by the administrative team, who assessed patients' individual needs and scheduled an appointment with adequate time.

The diagnostic imaging department ran 3 session clinics, 6 days a week (morning, afternoon and evening). From November 2022 to November 2023, diagnostic imaging outpatient activity had increased by 31%. The service had carried out some expansion work to provide additional capacity. This included the leasing of a second ultrasound machine due to a significant increase in demand. A business case was being developed to purchase a second ultrasound machine. An increase in demand for MRI appointments had also led to the service being extended from 4 to 5 days a week with plans.

The demand for DEXA appointments was such that the appointment booking system was open for appointments up to 150 days (21 weeks) hence. There were currently no firm contingency plans to increase the number of DEXA scans that could be carried out. There were plans to train further staff in carrying out the scans but there was no space in the department to accommodate a further DEXA scanner.

Managers worked to keep the number of cancelled appointments to a minimum, managers made sure they were rearranged as soon as possible and within national targets and guidance.

If a patient's appointment was cancelled, administrative staff would call the patient on the same day and rebook an alternative appointment as soon as possible. The number of patients who did not attend their appointment was low.

The service monitored reporting times for images. Figures showed that from January 2023 to November 2023, reporting times were as follows: for MRI scans, between 2 and 7 weeks; for CT scans, between 2 and 7 weeks; for plain film x-rays, between 1 and 8 weeks; for DEXA scans, between 1 and 8 weeks. Ultrasound scans were all reported on the same day.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with knew how to raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Posters in the waiting area directed patients on how to make a complaint.

Good

Diagnostic imaging

Managers investigated complaints and identified themes. The diagnostic manager told us that the service took complaints seriously and tried to resolve complaints at the point of care. They told us that patients were always offered a chance to report their complaints formally if they remained unhappy.

Staff understood the policy on complaints and knew how to handle them.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice. Managers told us about examples where patient feedback had been used to improve practice.

For further information on complaints please refer to the surgery report.

Is the service well-led?

Good

We previously rated outpatients and diagnostic imaging as one core service. We now rate them separately. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

For detailed findings on leadership, please see the well-led section of the surgery report.

The service had a clear leadership structure. There was a radiology manager for the department who also acted as one of the radiation protection supervisors. They oversaw the day to day running of the service. They were an experienced radiologist and had worked in the hospital for some time. There was an area radiology manager who supported the managers in 10 hospitals in the North West.

Staff told us that they felt well-supported by the departmental manager and had opportunities to learn and progress. They also told us that senior leaders were very visible in the hospital, knew all the staff and they encouraged staff to speak to them about any issues.

The manager told us that they had the opportunity to and had undertaken a Ramsay Hospitals course in management.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

For detailed finding on vision and strategy, please see the well-led section of the surgery report.

Good

Diagnostic imaging

The diagnostic imaging department had a local strategy in place that fed into the hospital wide strategy where there were 5 strategic objectives for 2023/24. These were based on patient safety, engagement, development and retention of staff, improvement to clinical service delivery and financial performance.

The hospital's values and clinical priorities were clearly displayed on notice boards across the diagnostic imaging department.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

For detailed findings on culture, please see the well-led section of the surgery report.

Staff that we spoke with were motivated and positive about their work and told us that they felt supported and valued. They felt that they worked together well as a team to provide good patient-centred care.

The last staff survey showed that, in the department, a high number of respondents were proud to work for the organisation.

Staff told us that senior managers had an open-door culture and encouraged staff to raise concerns. There was freedom to speak up guardian in the hospital and staff knew who they were.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

For our detailed findings on governance, please see the well-led section of the surgery report.

There was a clear governance structure for the department.

The manager attended the clinical governance committee meetings with other departmental heads to review policies and procedures, discuss incidents and complaints and any safety issues.

Heads of departments held monthly meetings with set agendas.

There were monthly staff team meetings within the department. This meeting had a standard agenda that included a review of actions; business matters; departmental updates; continued professional development updates; learning; regulatory updates and people issues. We reviewed the minutes from the last team meeting and found them to be well-ordered and comprehensive.

The hospital had a medical advisory committee (MAC) which was made up of consultants who worked at the hospital and included radiologists.

Good

Diagnostic imaging

Annual Radiation Protection Committee meetings were established and attended by the diagnostic imaging manager as the radiation protection supervisor.

We looked at the recruitment files for 2 radiologists, a radiographer and a radiology assistant from the diagnostic and imaging services.

We found evidence that suitable checks had been carried out prior to commencement of employment in the files we looked at. This included identification checks, proof of qualifications and mandatory training, at least two employment references, Disclosure and Barring Service (DBS) checks and professional body registrations and revalidations.

The hospital reported there were no outstanding queries relating to practising privileges. The 2 radiologist's files we looked at showed up to date appraisals and indemnity certificates and the consultants were listed on the GMC specialist register relevant to their specialty area. The radiographer was registered with the Health and Care Professions Council (HCPC).

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

For our detailed findings on management of risk, issues and performance, please see the well-led section of the surgery report.

The key risks relating to the diagnostic imaging services were recorded on a departmental risk register that was incorporated into the hospital wide risk register. The risk register showed that key risks were identified and control measures were put in place to mitigate risks. Risks had a review date and an accountable staff member (such as the department manager) responsible for managing that risk.

The top 3 risks identified in the department were waiting times; reporting times and continuity of the service if equipment broke.

Staff were aware of how to record and escalate key risks on the risk register. A risk scoring system was used to identify and escalate key risks to the hospital risk register.

Key risks and risk register entries relating to the diagnostic imaging services were reviewed at monthly departmental meetings as well as routine clinical governance, health and safety, information governance, medical advisory committee and senior leadership team meetings.

There was a structured programme of audit covering key processes such as infection control, patient records and medicines management. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through routine team meetings, safety huddles, performance dashboards and newsletters.

Good

Diagnostic imaging

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

For our detailed findings on information management, please see the well-led section of the surgery report.

There were systems in place for the safe storage, circulation and management of electronic and paper-based records such as patient records, performance reports, audit records and meeting minutes.

Staff completed information governance training as part of their annual mandatory training. Records showed 100% of eligible staff had completed this training.

The manager reported there had been no data breaches that were reportable to the Information Commissioner's Office (ICO).

Electronic systems (such as to store records and manage patient appointments) required password access. Diagnostic scan results, reports and images were stored electronically and could be accessed by staff in other parts of the hospital, such as during routine outpatient consultations.

Staff could access information such as policies and procedures in paper and electronic format. The policies we looked at were version-controlled, up to date and had periodic review dates.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

For our detailed findings on engagement, please see the well-led section of the surgery report.

Staff felt well informed about what was going on within the hospital and hospital group and received any updates daily at morning huddles. There was a monthly staff newsletter.

Representatives from the department were part of a staff engagement circle that met to talk about interdepartmental issues and events.

There were mental health first aiders for staff.

The service engaged with patients to gather feedback in a number of formats and make improvements.

Feedback from complaints was shared regularly with staff and managers.

Staff could give examples of changes that had been made based on patient feedback.

Good

Diagnostic imaging

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The diagnostic imaging department had a commitment to continuous improvement. We saw evidence of learning and improvement resulting from findings from audit results, incidents and complaints and shared learning was cascaded to staff to improve the service.

They had plans in place to replace aging equipment and also to introduce a new static MRI scanner. This would allow MRI scans to take place over six days a week.

Managers encouraged innovation with staff.