HCA Healthcare UK at the Wilmslow Hospital

Quality Report

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Date of inspection visit: 03 to 04 December 2018 and 27 February 2019
Date of publication: 31/07/2019

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

Ratings

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

Overall summary

HCA Healthcare UK operates six private hospitals and many diagnostic centres across the country, including The Wilmslow Hospital. HCA Healthcare UK also entered into a joint venture alongside NHS trusts. The Wilmslow Hospital is a private hospital in Cheshire, England, owned and operated by HCA Healthcare UK.

The hospital opened in May 2014, providing an outpatients, diagnostics and day case surgical facility for self-paying and NHS patients. The hospital also offers an outpatient service to children between the age of 0– 17 years old and surgery (including cosmetic surgery) to children aged 16-17 years old.

Summary of findings

The ten most common procedures included arthroscopic rotator cuff repair greater than 2cm (as sole procedure), coracoid bone block transfer for recurrent instability of shoulder and multiple arthroscopic operations on the knee (including meniscectomy, chondroplasty, drilling or microfracture).

The hospital operates across three floors, offering patients a full range of treatments including orthopaedics, general surgery, urology and dermatology.

The hospital serves the communities in the local area, but also accepts patient referrals from across the country and overseas. The hospital has had a registered manager in post since 2014.

The location houses an outpatient suite, diagnostic imaging and theatre day case unit, two laminar flow operating theatres, nine recovery bays, a walk out room and 13 consulting rooms. Additionally, the hospital has a dedicated women's health unit with ultrasound mammography diagnostic and full breast care service.

We inspected the outpatients and surgery provision at the hospital using our comprehensive inspection methodology. We carried out the announced part of the inspection on 3 December 2018 and 4 December 2018. We carried an unannounced inspection of diagnostic services on 27 February 2019 as it was not included in the initial inspection.

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

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

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

We rated the hospital good overall; surgery and diagnostics were rated as good. Outpatients was rated as outstanding,

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

Ellen Armistead

Deputy Chief Inspector of Hospitals (North)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as good overall. The service had an exemplary record of mandatory training compliance for theatre staff. Overall compliance for the department was 95%. Staff demonstrated excellent awareness of how to protect patients from abuse and the service worked well with other agencies to do so. The service had a comprehensive safeguarding work plan to ensure staff had the resources to protect patients from harm. The service had put in place extra safety measures to ensure any waste that may need to be tracked could be easily identified. The service had systems in place to manage emergency procedures. The service had a robust system for assessing patients at risk and staff completed and updated risk assessments for each patient. The service had enough medical, nursing and operating department staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. The service had a robust medicines management policy developed in line with national standards and regulations. The service had an excellent culture of incident reporting and staff were fully aware of the correct process and procedures. There was a strong emphasis on learning from incidents. The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance. Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other preferences.

Summary of findings

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
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 monitor the effectiveness of the service.
Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
The service had a robust process for consent which was checked thoroughly and reviewed throughout the patient's pathway.
Staff consistently demonstrated professionalism and competence in their roles. Patients told us they were constantly reassured by the staff depth of knowledge and were extremely confident in the staff looking after them.
Staff provided emotional support to patients to minimise their distress. Patients told us they were naturally anxious before surgery and staff constantly checked to ensure emotional support was provided.
Staff involved patients and those close to them in decisions about their care and treatment. We observed consistency in staff consideration and their desire to ensure patients were kept safe.
There was a very high standard of patient pathways that included pre- and post-operative support for patients.
We observed staff acknowledging patients' individual needs. We observed patient records of assessments where individual requirements were discussed.
The service did not have a waiting list as all surgery was elective and access to the service was flexible to meet patient's needs.
Staff demonstrated a proactive approach to continuous learning from complaints and concerns.
There was a very well established, proactive senior management team
The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups. Staff we spoke with were very clear on the service vision and strategic framework.

Summary of findings

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
There was a very strong culture of staff feeling supported and confident to challenge practice.
The hospital had a highly established and effective governance structure. They systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.
The service had systems in place to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
The service was committed to improving services by learning from when things went well or when they went wrong, promoting training, research and innovation.

Outpatients

Outstanding ☆

The service had processes and systems in place to keep patients safe. All staff were provided with mandatory and safeguarding training to ensure staff had the right knowledge to keep patients free from harm. The service reported all staff had completed this training.
All areas we inspected were cleaned to a high standard. Staff followed HCA Healthcare policy for waste management processes. Waste was appropriately labelled and segregated
Equipment was well maintained, we saw that service level agreements were in place to maintain equipment across all areas.
We found exceptional practices to improve practice through incident reporting, staff were encouraged to provide detailed descriptions of incidents so that leaders could implement action across the hospital to prevent other anticipated risks.
Records were completed appropriately and could only be viewed by staff who had access to the electronic system.
The service had staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and

Summary of findings

treatment. Staffing levels and skill mix was planned and reviewed by the service lead twice daily to address any shortages. The resident medical officers (RMO) was available during opening hours.

Patient's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure the consistency of care was in line with evidence-based guidance. The service regularly updated policies and procedures in line with new guidance.

Staff actively engaged in activities to monitor and improve quality of care and patient outcomes. Outcomes were routinely collected and monitored to ensure the service was delivering consistent care. Regular audits had been completed and subsequent action plans were carried out. For example, the service participated in the corporate audit programme that demonstrated compliance and performance.

The service ensured staff were competent in their roles by providing induction programmes, appraisals and supervision. There was a strong focus on ensuring newly qualified staff were supported through competency based frameworks, shadowing senior staff and by attending comprehensive corporate and site inductions.

We found senior staff had an excellent ethos to supporting staff to upskill themselves through training days and development programmes. Staff were proactively encouraged to acquire new and transferable skills and share best practice.

The service was committed to working collaboratively so that patients received a seamless service. Staff coordinated person centred care so that patients could move between different services.

The service did not see any patients who were detained under the Mental Health Act 1983. However, staff understood the importance of complying to the Mental Health Act code of practice.

Patients were truly respected and valued individuals. They were empowered as partners in their care, staff took social and emotional and physical needs into consideration.

Staff cared for patients with compassion, treating them with dignity and respect. Feedback from patients

Summary of findings

who used the service and those close to them was continually positive about the way staff treated them. We observed jovial interactions between patients and staff, which showed the great rapport between them.
There was a strong visible person-centred culture, staff were passionate and motivated to deliver the best care possible. Patients we spoke with said they felt empowered to give their opinions and thoughts about their treatment plan and felt confident that staff took into consideration, their individual preferences when delivering care.
Patients, families and carers gave positive feedback about their care.
Patients thought that staff went the extra mile to support them and their expectations. Patient surveys demonstrated that 100% of patients recommended the service.
The department tailored their services to meet the needs of individuals, this meant care was delivered in a way that promoted flexibility, choice and continuity of care.
There were innovative approaches to providing holistic and person-centred care. We heard of positive examples where staff changed clinics to accommodate patient needs.
Patients could access services and appointments in a way and at a time that suited them. Appointments were made on an individual basis. Nursing and medical services were accessible at all times including out of hours if required.
The service had robust systems in place to ensure complaints were effectively dealt with. Staff spoke about improvements that had been made as a result of learning from reviews and complaints.
Leaders at all levels demonstrated the high level of experience, capacity and capability needed to deliver person-centred care. It was evident from discussions that leaders empowered staff to develop in their role.
The hospital's strategy supported HCA's vision and values, it underpinned the objectives and plans to extend the hospital's facilities and services. We saw that the strategy was fully aligned with the wider health economy. This was achieved by collaborative working with internal and external stakeholders.
HCA's values were firmly embedded in practice across the outpatient department.

Summary of findings

We saw that leaders recognised and understood the challenges to quality and sustainably. Minutes from governance meetings showed that the leadership team had put actions in place to address them.
There was a systematic and integrated approach to monitoring and reviewing progress against the strategy. We found all staff in the outpatient's department demonstrated commitment to best practice. They escalated risks appropriately which were reviewed and managed through the performance and risk management systems and processes.
Staff were extremely proud of the hospital and the colleagues they worked with; teams worked cohesively to support each other across all functions of the department.
All staff focused on improving the quality and sustainability of patient care, making sure their experience was excellent. They were fully engaged in improvement methodologies and strived to achieve a higher quality of care.

Diagnostic imaging

Good

The diagnostic service included magnetic resonance imaging, mammography, ultrasound scans, x-ray and fluoroscopy mainly for self-paying patients.
We reviewed records and spoke with patients. We found that there was sufficient staff with the right skills. Equipment and environment checks were carried out.
Staff were caring and compassionate. There were no waiting lists and some clinics were one-stop services. There were management processes in place with visible leadership.

Summary of findings

Contents

Good

The Wilmslow Hospital

Services we looked at
Surgery; Outpatients; Diagnostic Imaging

Summary of this inspection

Background to HCA Healthcare UK at the Wilmslow Hospital

HCA Healthcare UK operates six private hospitals and many diagnostic centres across the country, including The Wilmslow Hospital. HCA Healthcare UK also entered into a joint venture alongside NHS trusts. The Wilmslow Hospital is a private hospital in Cheshire, England, owned and operated by HCA Healthcare UK. The hospital opened in May 2014, providing an outpatients, diagnostics and day case surgical facility for self-paying and NHS patients. The hospital operates across three floors, offering patients a full range of treatments including orthopaedics, general surgery, urology and dermatology. The hospital serves the communities in the local area, but also accepts patient referrals from across the country and overseas. The hospital has had a registered manager in post since 2014.

The location houses an outpatient suite, diagnostic imaging and theatre day case unit, two laminar flow operating theatres, nine recovery bays, a walk out room and 13 consulting rooms.

Additionally, the hospital has a dedicated women's health unit with ultrasound mammography diagnostic and full breast care service.

Our inspection team

The team that inspected the hospital comprised of two CQC inspectors, and two specialist advisors with expertise in outpatients and surgery. The team that inspected diagnostic services comprised a CQC lead inspector, a CQC team inspector, and a specialist advisor with expertise in diagnostics. The inspection team was overseen by Nicholas Smith, Head of Hospital Inspections.

Information about HCA Healthcare UK at the Wilmslow Hospital

During the inspection we visited the surgery department and the outpatient's department.

We spoke with 33 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, a radiologist, radiographers and senior managers.

We spoke with 22 patients and two relatives. We received three 'tell us about your care' comment cards which patients had completed prior to our inspection. We reviewed 31 patient feedback comments from the previous three months audit of patient satisfaction.

During our inspection, we reviewed 16 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital had not been inspected since registration with CQC.

Activity (August 2017 to July 2018)

- In the reporting period August 2017 to July 2018 there were 1835 day case episodes of care recorded at the hospital; of these 50% were NHS-funded and 50% other funded.
- There were 8,620 outpatient total attendances in the reporting period; of these 82% were other funded and approximately 18% were NHS-funded.

248 surgeons worked at the hospital under practising privileges and two regular resident medical officers (RMO) worked on a weekly rota. The hospital employed 22 registered nurses, five health care assistants and 31 other staff including receptionists, housekeeping and maintenance staff. The hospital also had their own bank staff. The hospital had access to registered children's nurses who were employed on the bank.

The accountable officer for controlled drugs (CDs) was the Chief Nursing Officer.

Track record on safety

Summary of this inspection

The hospital reported;

- 149 clinical incidents of which 93 resulted in no harm and 56 resulted in low harm,
- Zero never events,
- Zero serious injuries,
  - Zero incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),
  - Zero incidences of hospital acquired Methicillin-sensitive Staphylococcus aureus (MSSA),
  - Zero incidences of hospital acquired Clostridium difficile (C.diff),
  - Zero incidences of hospital acquired Escherichia coli (E. coli),
  - 19 complaints.

Services provided at the hospital under service level agreement:

Pathology

Breast Histology Specimens

Blood Products

YAG Laser

Physio Theatre Discharges

Semen Analysis

Audiology Testing

Decontamination/CSSD

Housekeeping/Catering/Laundry

Medical Device Maintenance

Clinical and or non-clinical waste removal

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as Good because:

- There were comprehensive systems to keep people safe, including processes and systems to safeguard patients and carers from abuse.
- The hospital had an exemplary record of staff mandatory training compliance which included safeguarding, infection control and information governance.
- The hospital proactively monitored and managed safety by anticipating risks to patients using the services. This was embedded in practice and was recognised by staff as their responsibility. It ensured that the department had sufficient nursing and medical staff to ensure patient safety, and nursing staff had access to a resident medical officer during opening hours.
- The hospital had high staffing levels and patients did not wait long to be seen by doctors or nurses. The services reported no unfilled shifts and all relevant staff had up to date training.
- Staff discussed changes they had made to the services they offered to patients, after they had identified any risks. All incidents were appropriately documented and reviewed by a senior manager.
- All areas we inspected were extremely clean and tidy. Staff were proficient in making sure the department was orderly and neat.
- Theatre suites and anaesthetic rooms were very well equipped with advanced technology, monitoring systems and displays. Each theatre was equipped with laminar flow which safely filtered air away from the theatre.
- Within the diagnostics department, contrast and emergency medicines were stored securely.
- The service had systems in place to manage emergency procedures.

Are services effective?

Good

We rated effective as **Good** because:

- The service used evidence based processes and best practice which followed recognised protocols. They used technology to improve the service they provided.
- The service had clear, well written standard operating protocols and policies.

Summary of this inspection

- Staff participated in audits and projects to improve quality and patient outcomes. We saw evidence of active participation in accreditation schemes to ensure recognition of excellence from creditable external bodies.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- We found continuing development of staff's skills, competence and knowledge; managers proactively supported and encouraged staff to acquire new and transferable skills and share best practice through learning and development.
- The service provided annual staff appraisals and had a compliance rate of 100% completion at the time of our inspection.
- Staff understood their obligations regarding patient consent and the Mental Capacity Act.

Are services caring?

Good

We rated caring as **Good** because:

- We observed patients were truly respected and valued as individuals. We observed excellent interactions between staff and patient during consultations.
- Staff empowered patients who used the service by listening to their opinions and thoughts about their treatment plan. Staff took into consideration, the patient's individual preferences when delivering care.
- Staff were highly motivated to offer care that was kind and promoted patient dignity. They were fully committed to working with patients to make their experience at the hospital a positive one.
- Feedback from patients who used the service was continually positive about the way staff treated them. Patient surveys demonstrated that 100% of patients recommended the service.
- Patients and those close to them were actively involved in their care and treatment. Care was tailored to meet their needs following discussions with clinicians.
- All patients we spoke with fed back that staff went the extra mile, and the care they had received exceeded their expectations.
- Staff demonstrated a strong patient-centred culture, recognising the emotional and psychological needs of patients, relatives and carers.

Are services responsive?

Good

We rated responsive as **Good** because:

Summary of this inspection

- The department offered services tailored to meet the needs of individual patients. Services offered within the outpatient department delivered care accordingly to the needs of people using the service. This was to ensure flexibility and choice.
- The facilities and premises across the outpatient's department was sufficiently designed to meet the needs of patients.Patient waiting times were consistently low and the clinic could quickly adapt to the needs of individual patients to provide care in a way that suited them.
- There were excellent patient pathways developed in collaboration with other services.
- People could access the service when they needed it. Patients had direct access to a variety of specialist services on site and could be assessed the same day.

Are services well-led?

Outstanding ☆

We rated well-led as **Outstanding** because:

- The department was led by compassionate and effective leadership at all levels who demonstrated their high level of experience, capacity and capability to deliver excellent and sustainable care.
- The vision and values of the hospital was well embedded across the service and staff were focused on achieving these.
- The service had a clear quality framework with the focus on patient safety and quality care.
- The culture and attitude among all staff was to offer high-quality patient-centred care. We heard excellent examples of how learning had driven improvements in service.
- The service had a well-established and effective governance structure. Governance arrangements were reviewed to ensure the practice reflected best practice. We saw systems in place to improve care outcomes.
- Staff demonstrated commitment to best practice at all levels by identifying, monitoring, and understanding their risks. There were systems in place to ensure a consistent approach amongst staff to reduce risks. For example, daily, monthly, annual checks were in place and reviewed to make certain the service was safe.
- There was strong team-working ethos and staff engaged well with each other to improve the quality of care and patient expectations. We heard of excellent examples of innovation to improve the provision of the outpatient's department.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Outstanding	Good
Outpatients	Good	N/A	Outstanding	Good	Outstanding	Outstanding
Diagnostic imaging	Good	N/A	Good	Good	Outstanding	Good
Overall	Good	Good	Good	Good	Outstanding	Good

Good

Surgery

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

Information about the service

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

Are surgery services safe?

Good

We rated safe as **good.**

Mandatory training

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. Training included infection prevention and control, basic and immediate life support, health and safety, consent, fire safety and disability awareness.
- All applicable staff were required to complete sepsis training in accordance with the HCA recognition and management of sepsis and septic shock policy.
- Staff told us they could easily access mandatory training through the service electronic learning academy. There was face to face training provided for staff such as manual handling and life support. The service offered staff mandatory training days where several of the mandatory training subjects were delivered. Staff were allocated protected time to complete these.
- The service had an exemplary compliance record of mandatory training for theatre staff. Eligible staff in 34 mandatory training subjects were 100% compliant. In six mandatory training subjects, all except one member of staff were 100% compliant. Overall compliance for the department was 95%.
- Staff told us that as well as completing role specific mandatory training, they opted to complete any training modules they felt would enhance their learning. We observed staff development portfolios where all completed training and development was recorded. Staff told us the service encouraged learning and development and staff were given opportunities to develop through eLearning and face to face training sessions.
- The service provided training on screening and application of sepsis protocols. The training was delivered in conjunction with the service infection prevention and control training. At the time of inspection all but one member of eligible staff was compliant in this training. We reviewed the infection prevention and control team meeting minutes where this was addressed.
- We observed two staff induction folders and reviewed sections where staff had used reflection following their training. There were excellent reflective narratives of duty of candour responsibilities and staff understanding of the process following the mandatory training.
- Staff with practicing privileges were not required to complete the service mandatory training but had to show evidence of compliance elsewhere before they were permitted to practice at the service. This was closely monitored by the medical advisory committee and staff were sent regular reminders when they approached the expiry dates.

Good

Surgery

Safeguarding

- Staff demonstrated excellent awareness of 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.
- All eligible staff had completed mandatory safeguarding training levels one and two for adults, children and young people.Staff who required level three training had completed this. Staff told us they received safeguarding supervision monthly which was tailored to meet the requirements of their service.
- The hospital had a safeguarding lead who was trained to level 4 and the designated safeguarding lead for the organisation was available to all staff. All staff we spoke with knew who this was and how to access them. Any safeguarding alerts or concerns were discussed at the service local operational meetings. There was also a regional safeguarding committee that met each quarter where all safeguarding concerns were discussed. When necessary, the safeguarding lead also escalated concerns to the monthly quality and governance group.
- We observed the templates in the electronic patient record assessment for staff to complete any safeguarding concerns. If a concern was identified, a check box on the template was completed which prompted staff to take the appropriate reporting route. For example, one of the prompts informed staff to notify the safeguarding lead. The template also provided a list of safeguarding risks for staff to consider.
- The hospital had a comprehensive safeguarding work plan to ensure staff had the resources to protect patients from harm. There were clear goals and actions for all staff to embed safeguarding awareness and governance. Senior managers were tasked with monitoring the work plan and ensure progress was on track. We reviewed the work plan and observed some of the systems developed to support staff.
- We observed a clear emphasis on maintaining staff competency in safeguarding awareness. Staff carried pocket sized reference guides with safeguarding prompts. Staff told us they rarely had to raise any safeguarding concerns but were fully aware of the process to report and the recording template to document concerns in the patient electronic record. Staff said they had regular updates from the safeguarding lead and this refreshed their knowledge and awareness of things to consider.
- The service held a daily safety huddle where safeguarding concerns were raised if necessary. Safeguarding was also a running agenda item for all team meetings where concerns were discussed.

Cleanliness, infection control and hygiene

- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- There had been two surgical site infections reported between July 2017 and June 2018.
- All recovery rooms had a wash basin with hot and cold running water. There was adequate personal protective equipment such as gloves in three sizes and aprons. There were hand sanitisers on the walls at the entrance and throughout the department. Staff also carried small portable hand sanitisers in their pockets.
- We observed staff decontaminate their hands upon entry and exit to the department, anaesthetic areas and recovery rooms. Staff decontaminated their hands before and after patient interactions.
- The service carried out hand hygiene audits monthly to monitor staff compliance with effective infection control techniques. We reviewed three hand hygiene audits for September, October and November 2018. Compliance for September was 80% identifying four out of 20 members of staff non- compliant with effective hand hygiene. The hospitals internal target was set at 100%. Hand hygiene compliance rate for October 2018 had increased because nursing staff told us they were confident in challenging poor practice.
- Staff had observed areas of improvement and addressed these at the time of the audit by developing a hand hygiene poster which was located at various infection control 'hotspots' such as sinks, toilets and access routes. The poster also prompted staff to ensure they were bare below elbows and gave appropriate messages on hand hygiene.

- To improve infection control standards, staff increased the regular audits and carried out unannounced 'spot checks' across the department. The hospital introduced the 'keep me safe' campaign which was rolled out in November 2018. This focused on getting back to basics with infection control such as hand washing techniques using the World Health Organisation '5 moments for hand hygiene'. The infection control audit for November 2018 identified 100% compliance in hand hygiene indicating an improvement following the actions that had been put in place.
- We observed equipment that had been decontaminated throughout the theatres. Staff were responsible for general cleaning and disinfecting the equipment they had used and segregate disposable items into the correct waste stream. Equipment that had been cleaned was labelled with a sticker to identify the date and time of cleaning and signed by the staff member. We reviewed the infection control audit for November 2018 which identified 100% compliance of cleanliness for equipment and the environment.
- There was a service level agreement with an external company for housekeeping arrangements. The team were responsible for cleaning the theatre, anaesthetic rooms, recovery rooms and communal areas. The housekeeping team were available on site between 6 am and 9 pm and cleaning schedules were negotiated between teams to coordinate access to various areas of the department. This ensured the process did not interfere with theatre lists and patient recovery. Staff told us the teams worked very well together and reported no issues.
- We observed clinical waste disposed of appropriately. All clinical, non-clinical and offensive waste was segregated and disposed of in the correct waste stream. We observed the correct colour coding system used throughout the theatre and in patient's recovery areas. There were also colour coded posters informing staff of the correct waste stream to use.
- The service had put in place extra safety measures to ensure any waste that may need to be tracked could be easily identified. Theatre staff used a unique numbered ID tag to tie waste bags which was associated to the individual patient. The ID number was recorded in the electronic tracking system and in the patient notes. This meant any waste that needed to be tracked back to the individual could be done anonymously.
- Systems were in place to minimise the risk of legionella. We saw evidence of water flushing processes.

Environment and equipment

- The service had suitable premises and equipment and looked after them well.
- The service had two theatre suites covering a variety of specialities including orthopaedics, cosmetic surgery, ophthalmic, ear, nose and throat, plastic surgery, pain management and urology. Each theatre suite had adjoining anaesthetic rooms.
- We observed both theatre suites and anaesthetic rooms were very well equipped with advanced technology, monitoring systems and displays. Each theatre was equipped with laminar flow which safely filtered air away from the theatre and prevented any bacterial contamination from being recirculated. This meant the theatres had the highest degree of safety standards for staff and patients.
- There was a clear thoroughfare between the recovery rooms where patients were initially admitted, through to the anaesthetic room and adjoining theatre. Patients were transferred directly to the anaesthetic room, into theatre and returned to their allocated recovery room after surgery.
- The service had nine individual recovery rooms. Patients were admitted to their own room before surgery and returned to the same room after surgery. All rooms were very well equipped to carry out patient observations. There were lockers in each of the recovery rooms where patients could safely leave their belongings and redress before being discharged home.
- The service had two portable resuscitation trolleys with defibrillators which were fully equipped with the appropriate equipment and medicines we expected to see. One trolley was set up for theatre and one for recovery. Both were clearly signposted and all equipment on the trolleys was fit for purpose and in date. A full review of the trolleys was carried out weekly and safety checks were reported at the daily safety huddle which mitigated the risk of checks being missed.

The hospital also had an annual independent audit check of resuscitation trollies. The latest audit confirmed good compliance with Resus Council UK standards.

- The service had systems in place to manage emergency procedures. For example, the service had separate emergency trolleys prepared to manage difficult airways, malignant hyperthermia and major haemorrhage. All trolleys were equipped with appropriate equipment to manage such events. These were reviewed daily to ensure all equipment was fit for purpose.
- The service used an external facility where equipment was sent for decontamination and sterilisation once it had been used. Equipment was collected daily and staff told us the turnaround for replacement equipment was usually within 12 hours. This could be requested sooner via a telephone call to the external facility if required.
- All theatre trays had a unique identifier sticker with a barcode which was placed in the patients notes to identity what had been used. The code was scanned and recorded in the electronic log before being collected by the external service. The service kept an electronic log of all equipment used and this could be cross matched against the patient's ID number. The service used a tracking system to identify all sterile equipment and theatre trays used.
- Staff could access all equipment as they needed it. We observed a well-stocked store room with intact sterilised trays. There was clear signage for staff to identify the contents of the trays and each had the unique bar code which staff scanned when it was used. Staff told us the system was very effective and was much safer since the packs were easily tracked.
- All equipment we observed was in good working order, fit for purpose and had been well maintained. Each item of equipment had a label indicating its last service date and when this was next due for servicing. The service kept an electronic record of all equipment needing to be serviced. This was held locally and the service lead monitored this to ensure all equipment was fit for purpose.
- The service had a contract with a local external company for servicing and maintenance of all equipment on site. Equipment was serviced annually and we observed records indicating these had been completed. Dates for servicing were booked in advance to ensure access to the relevant pieces of equipment which allowed for flexibility with theatre schedules and avoid any disruption to the service. For manufacturer issues, the service contacted the supplier. There was a local representative for the supplier who could be contacted by telephone and email.
- The service completed regular environmental audits to ensure the service was clean and maintained to the highest standard. The service consistently met all audit standards which ensured a safe environment for staff and patients.
- The service had a communication, control and coordination framework for use in responding to and recovering from incidents including internal business continuity. This was supported by business continuity Plans and Emergency Planning, Resilience and Response Plans.

Assessing and responding to patient risk

- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary. We observed six patient records. All records discussed potential risks and there were dates of those risks being reviewed. All records contained detailed observation charts including blood pressure, respiratory rate and pulse taken every five minutes during the first 30 minutes of recovery.
- The hospital had a national early warning score system (NEWS) in place. The hospital used a paediatric early warning score system for children under the age of 16. The hospital audited a sample of NEWS charts monthly to check they were fully completed, the NEWS scores were added correctly and escalated appropriately. Audit results showed compliance.
- There was a clear standard operating protocol for staff to follow when caring for a child. All relevant information was accessible within the protocol.
- All patients admitted for surgery were risk assessed using the World Health Organisation (WHO), five steps to safer surgery. This was a system to ensure patients were kept safe and the checklist was reviewed at various stages of the patient's pathway. The service conducted regular audits of the WHO checklist. Data between

January 2018 and August 2018 varied between 94% - 98.5% compliance. This improved further between September to November 2018 with the service reporting 100% across all three months.

- The service had a protocol in place for unplanned transfer if a patient become acutely unwell. The service reported two transfers between August 2017 and July 2018.
- All patients had access to a 24-hour patient line after they left the hospital. They were asked to call this hotline if they had any post-operative problems. All calls were dealt with by a registered nurse.
- The service carried out regular audits to ensure staff were compliant in utilising the WHO checklist. Areas of non-compliance were addressed through a series of actions and reviewed in the following months audit. We reviewed audit results where actions were identified and the outcomes of compliance had improved. For example, the regional clinical practice facilitator and the service matron developed a training programme to address areas of non-compliance and ensure the WHO checklist was accurately recorded in all standards. There was a significant improvement in staff compliance following the interventions and we reviewed data indicating 100% compliance for the four months prior to our inspection.
- The service had a clear, comprehensive policy and standard operating procedure (SOP) for the safe management of invasive procedures. This had been reviewed in October 2018 and developed in line with national safety standards for invasive procedures guidance. This included prompts for staff using the world health organisation surgical safety checklist and guidance on safe preparation, treatment and discharge of patients from the department.
- The service had a robust system for assessing patients prior to admission. There were fixed criteria to accept patients and this was reviewed by anaesthetic and consulting staff. Patients usually attended the service outpatient's clinics prior to admission where initial risks were identified and assessments were completed.
- When patients were admitted for surgery, the initial risk assessments were reviewed and further risk assessments were completed. These included risks associated with the surgical procedure being undertaken and other risks such as the patients risk of falls. Staff told us all patients were assessed as a higher risk of falls post-surgery due to sedation and anaesthetics and this was identified as a potential risk during assessment.
- There were robust systems in place for managing actual and potential patient risks. The service developed a standardised observational audit which was completed monthly by each department. This ensured risks to patients such as falls and infection control were regularly audited to mitigate risks. The service monitored the results to maintain patient safety and responded to risks as they were identified.
- Staff demonstrated awareness and their responsibilities for patients at risk of developing venous thromboembolism (VTE). Risk assessments were developed in line with national guidelines and the service carried out regular audits to monitor compliance. We reviewed audits completed in July and August 2018 that indicated all standards were met by staff. We reviewed patient records that showed risk assessments had been completed and evaluated post operatively.
- The service reported no 'Never Events'. Never events are serious incidents that are preventable because guidance or safety recommendations should have been implemented. Staff had a raised awareness of potential never events despite the service rarely encountering them. The potential for never events occurring was addressed through patient risk assessments and consent to surgery procedures.
- Teams in each department held a morning safety huddle where topics such as the surgery lists, staffing levels, housekeeping and any concerns or issues were raised. We observed the daily safety huddle where the heads of all departments attended and was led by the service clinical matron. All departments at the location were represented at the meeting which meant all staff were aware of potential risks or issues that may affect services. This was a brief and well-coordinated meeting addressing safe plans for the day and a review of any concerns from previous days.

- The service kept two units of O negative blood on site for use in the event of emergency. There was a clear standard operating procedure to guide staff in the appropriate use of blood products and applied to those trained in administration.
- The service reviewed results from audits carried out across all HCA healthcare services that identified a variation of patients at risk of falling. This led to a review of the patient falls risk assessments to identify potential risks for patients attending the service. Staff demonstrated an excellent awareness of patients at risk of falls particularly following surgery and during episodes of partial sedation for example. A complete record of falls risk assessment was included in the patient care records.
- The service had an emergency response team of clinical and non-clinical staff located throughout the hospital. This meant there was always someone qualified within each department trained in the event of a clinical emergency. The service provided staff training in intermediate life support which meant staff were competent to act as first responders and treat patients in cardiac arrest. Eligible staff were 100% compliant in their training at the time of inspection.
- The service had a robust standard operating procedure and policy for managing emergency events such as cardiac arrest and recognition of patients with sepsis. The procedure outlined the roles and responsibilities of staff and clear directions for various emergency procedures. Staff were allocated roles according to their competence at the beginning of each shift by the registered medical officer and issued a bleep to be alerted in the event of an emergency. These staff remained the emergency response team for that shift and staff we spoke with were clear on their roles and responsibilities. We spoke with staff who were emergency response first responders and completed immediate life support training to support their role.
- The hospital commissioned services to carry out simulated emergency exercises to evaluate the skills of staff and their response to emergency situations. We reviewed the outcomes of training completed in April and October 2018. These included responding to chest pain and subsequent cardiac arrest, early recognition of a patient with sepsis and transfer to emergency or other services. Feedback was given by assessors and lessons learned were discussed after the event. We reviewed actions and recommendations developed following training to maintain competencies and improve practice.
- The service developed a standard operating procedure to support staff on the process and their responsibilities for transferring patients to other services if required. The procedure outlined staff roles and guidance to support staff in decision making. Staff told us they contacted the on-site registered medical officer if they had any concerns about a patient and were clear on their responsibilities when responding to emergency procedures.
- Staff had developed their own tools and flowcharts to assist them in processes for escalating risks, reporting incidents, falls risks and safeguarding concerns. There were easy to follow flowcharts that directed staff through the process for managing each event. Staff told us they had regular meetings to review safety processes.

  Staff told us they had identified a potential risk with cardiac defibrillator checks being missed. The team added enhanced safety checks by setting the equipment to carry out a 'self-check' at 3 am every day. When the team came on duty they rechecked the equipment and compared this to the results of the equipment self-check. This was embedded as part of the daily safety checks and a copy of all electronic test receipts was kept in a log for audit purposes. We reviewed a folder with all checks completed for the month of November 2018.
- The hospital had an annual external health and safety review. The latest reported showed high levels of compliance with health and safety management.

Nursing and support staffing

- The service had enough nursing and operating department staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The service reported no unfilled shifts between May and July 2018.
- Staff sickness rates varied between 6% and 0% between August 2017 – July 2018.

- The service reported an improving picture for staff turnover rates, from 27% in August 2016 to July 2017 to 9% the following year.
- The service used a digital workforce planning tool to determine the number of staff required based on the service activity. This was further reviewed based on the complexity of the procedure and individual patient requirements. Due to the nature of the service, all surgery was planned which meant staffing was assessed in advance to ensure the appropriate number of qualified, competent staff were in place. On days where there were cancellations or no planned admissions, there were staff on duty in preparation for short notice arrangements.
- Children aged 16 and 17 years were seen in day case surgery. A paediatric nurse was present for the entire duration of the procedure.
- We observed a notice board in the department identifying actual and expected staffing requirements. These were discussed at the daily safety huddle and updated to ensure sufficient staff were on duty. The service had the appropriate number of staff on duty in accordance with the association of anaesthetists and the association of perioperative practitioner's standards. At the time of our inspection there was one surgeon, two scrub nurses, one anaesthetic practitioner, one recovery practitioner and one healthcare assistant. There were two listed procedures taking place.

Medical staffing

- The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- At the time of our inspection there were two resident medical officers (RMO) working alternate weeks, both employed through an agency. We spoke with one RMO who demonstrated an excellent understanding of their role and responsibilities. They told us that working alternate weeks with another RMO meant there was good continuity and handover which mitigated risks of anything being missed.
- The service had a robust system to monitor staff with practicing privileges. Practicing privileges are where a suitably qualified and competent practitioner is granted permission to work in an independent hospital, clinic, or private practice. Assessments were carried out by the Medical Advisory Committee including current workload, professional credentials and mandatory training. This was reviewed monthly and the service received a report to ensure staff were compliant and competent.
- The service had 248 staff with practicing privileges at the time of our inspection. Applications for practicing privileges were reviewed by the chief executive officer for suitability before being discussed in depth at the medical advisory committee. Staff who could not present current compliance with training or there was any delay in receipt of credentials, had their practicing privileges suspended. Suspensions remained in place until the service was satisfied all issues had been addressed.
- The service ensured consultants were easily accessible and could attend the hospital within 30 minutes of being called. Location of those applying for practicing privileges was considered as part of their application and as part of their contract, consultants had to allocate a named person who could be contacted when the consultant was not available.
- The service had 24-hour cover for registered medical officers (RMO) at a nearby service also managed by HCA Healthcare UK. Patients were given contact details in case of emergency. The service RMO forwarded a list of contact details and relevant information to the out of hours cover at the end of each shift. This meant if there were any issues or concerns patients were supported 24 hours a day if required and consultants could be contacted directly or indirectly.
- All medical staff employed by organisations, practiced in their speciality. The Medical Advisory Committee reviewed appraisals and the number of procedures carried out outside of HCA to assure the board the individual was competent in the speciality Many of the staff also practiced in other HCA Healthcare locations. This meant there were good working relationships with staff and a good understanding of the service values. There were many renowned and highly sought-after consultants practicing at the service.

Records

- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- All patient records were completed using the service electronic patient record system. There were also paper documents used to complete risk assessments, observations and general clinical notes. These were scanned onto the patient record on discharge. This meant there was a complete record of the patient interactions from admission to discharge.
- The service undertook six monthly records audits. An audit dated August 2018, showed 100% compliance with the standards.
- We reviewed six patient records during inspection. Staff completed thorough risk assessments, holistic assessments and care plans. All records were legible, clear with the relevant information we expected to see, signed and dated by the practitioner.
- Surgeons completed a record of their intervention in the patient's electronic record. Some surgeons recorded their information in a separate document which was added to the patient record. A copy of the interventions was sent to the patients GP on discharge.
- We observed paper records were stored in locked filing cabinets and kept in a separate room accessed only by staff using a key pad. These were locked at the time of inspection and records were retrieved as they were required. All paper documents were filed after being scanned onto the patient electronic record and stored in line with national data protection guidelines.

Medicines

- The service followed best practice when prescribing, giving, recording and storing medicines. Records we reviewed showed patients received the right medication at the right dose at the right time.
- The service had a robust medicines management policy developed in line with national standards and regulations. This include information on antimicrobial stewardship. There was also a comprehensive medicines management manual that outlined roles, responsibilities and best practice.
- There was a comprehensive audit programme for medicines management which included the safe storage of medicines, medicines safety thermometer and controlled drugs audits. There was also a record and audit of all contributions pharmacists made in their clinical areas to ensure patient safety and improve the quality and continuity of care. In June 2018, a report showed there had been eight interventions, in the previous three months, by pharmacists; there had been no harm and all the issues were resolved before reaching the patient. There was an action plan with clear recommendations to avoid recurrence and ensure learning.
- The Medicines Management Committee led on medicines optimisation strategies and provided assurance of meeting statutory responsibilities. This was done by monitoring compliance to the corporate medicines management policy and legislative guidance including Medicines and Healthcare products Regulatory Agency and Department of Health Alerts.
- The service had an onsite pharmacy and pharmacist who was accessible to staff and patients during opening hours. There was also support from a regional pharmacist manager and a pharmacist on call for out of hours support. The service had a robust standard operating procedure for pharmacy standards that supported best practice and requirements of the clinical pharmacy service.
- The registered medical officer met with the pharmacist each morning and discussed patient admissions for the day. They reviewed each patient's medicines on admission and prepared any medicines ready for discharge. This meant the risk of a delayed discharge due to waiting for medicines to take home was reduced.
- The service followed the department of health guidelines to help facilitate safer discharges and ensure medicines were dispensed in a timely manner. There were comprehensive audit reports completed to monitor prescription turn around times. The audit for the three months prior to our inspection identified 99% of prescriptions were dispensed in under 30 minutes with 1% in under 60 minutes. Results from the audit were used to highlight good practice and improve the service.
- The service used a pharmacy tracker tool to monitor prescribing and dispensing activity in the pharmacy department. Audit results were used to evaluate staffing

levels and the patient pharmacy experience. The pharmacy lead attended the pharmacy operational governance meetings where outcomes of audits were discussed.

- We reviewed six patient medicines charts. All were completed appropriately and contained the information we expected to see. All charts were signed and dated by the prescribing and administering practitioners.
- All intravenous fluids and medicines were stored safely in locked cupboards. Cupboards were held in rooms secured with a keypad and inaccessible to anyone without the relevant codes. Controlled drugs were secured in locked cupboards and a designated key holder was identified each day. A duplicate set of keys was kept elsewhere on site.
- We observed the management of controlled drugs policy was in line with current legislation and national guidance. All staff responsible for the administration and prescribing of controlled drugs were aware of the policy and how to access it. This was accompanied by a corporate code of practice that identified and informed those responsible for prescribing, dispensing and administering controlled drugs.
- Stocked medicines top-up to agreed stock levels took place on a regular basis in line with the service local policy and standard operating procedure. There was a controlled drugs log that was signed and dated appropriately and all checklists were reviewed in a timely way. Controlled drugs were stored and locked away from patient access areas.
- Staff checked temperature control for all fridges and freezers where medicines were kept. Staff completed a log indicating the temperatures and checked the contents to ensure these were in date. We observed this was completed and recorded daily.
- All prescribing decisions were documented in notes and staff took consideration to the patient's allergy status and any concomitant medications they were taking (including over the counter medication).

Incidents

- The service managed patient safety incidents well. Staff recognised incidents 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.
- The service had an up to date policy for reporting incidents and was easily accessible to staff on the service electronic system. Staff were encouraged to reflect on incidents to help mitigate risks in future. Key messages were promoted under the 'keep me safe' campaign through materials such as screensavers, emails, engagement sessions and senior management rounds.
- The service had an excellent culture of incident reporting and staff were fully aware of the correct process and procedures. We observed a strong emphasis on learning from incidents and this was confirmed by staff we spoke with. Staff gave examples of incidents they had reported and the lessons they had learned through weekly team meetings and team discussions.
- The service reported 149 incidents location wide during the reporting period August 2017 and July 2018. The information we received did not identify the number of incidents related to surgery but staff were informed of all incidents that occurred at the hospital to ensure lessons learned were shared.
- Staff told us that despite incidents being rated as low or no harm, all incidents were reviewed to identify any lessons that could have been learned from the event. 93 of the incidents reported were rated as no harm and 56 rated as low harm. 64 of those incidents were identified as non- clinical events such as equipment issues or estates matters.
- Staff told us they were encouraged to raise any issues or concerns as incident reports regardless of the event. This meant senior managers could assess the severity and potentially reduce the risks before they occurred.
- Staff told us they tried to anticipate potential risks before patients were admitted, mitigating the risks and preventing incidents occurring. Staff demonstrated an excellent understanding of what systems and resources needed to be in place to help mitigate preventable risks and incidents occurring.

Good

Surgery

- Senior managers told us staff responded to incidents immediately by initiating an analysis of the event and discussing the incident within the team. Staff regularly took the initiative to identify solutions and put systems in place to avoid them happening again.

Safety Thermometer (or equivalent)

- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.
- The service used NHS safety thermometer data to measure their performance against NHS services nationally. We reviewed data from the hospitals quarterly quality and safety review which indicated performance was within or better than safety performance targets. Areas such as pressure ulcers and falls for example were monitored. These were also measured against other HCA Healthcare UK services nationally and reported in the quarterly review dashboard.
- All staff we spoke with emphasised the importance of patient safety in all they did. We heard many examples of staff identifying potential patient risks and responding very quickly to identified patient risks.

Are surgery services effective?

Good

We rated effective as **good.**

Evidence-based care and treatment

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- We reviewed eight of the local policies including moving and handling, resuscitation, recovery discharge and pain management. All polices were in date and showed recent review by the clinical governance team. Policies were developed in line with national guidelines such as the National Institute for Health and Care Excellence, the association of anaesthetists and the association of perioperative practitioner's standards.
- The service had clear, well written standard operating protocols and policies for a variety of procedures. Staff told us whenever a change or development was made in the service, they were informed of a new or updated standard operating procedure (SOP). Staff had access to all SOP's electronically and received regular emails to inform them of any updates.
- The service completed regular audits for monitoring staff compliance of cosmetic surgery standards. These were developed in line with guidance from the Royal College of Surgeons (RCS) and set out the standards of good practice expected by the service. The service set a target of 100% compliance by all staff observed. We reviewed the most recent audit data of 20 patient records for November 2018 which indicated 100% compliance across all standards.
- The service identified patients meeting the criteria for submission to the national breast implant registry pre-operatively. All relevant data was submitted to the register as required.
- Patient documentation such as treatment plans, observational charts and identification was developed in line with national guidance such as the national patient safety advisory. Local policies and procedures were developed in line with national guidelines to ensure staff used evidence based systems to deliver care. This ensured staff delivered appropriate interventions and prescribed care.
- All staff we spoke with were aware of the service policies and procedures and showed us how to access them on the service electronic system. Staff gave us examples of reference to these when required and their participation in developing some of the standard operating procedures.

Nutrition and hydration

- It was unclear whether there was a policy regarding fasting times and whether admissions were staggered to minimise fasting periods.
- Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other preferences.
- All patients we spoke with were asked if they had any special dietary requirements during their pre-operative

assessment. This meant the housekeeping team had enough time to prepare any special requirements. Patient choice was reviewed once admitted to the department.

- Patients were offered a choice of menu before their surgery. Once the patient had recovered and was ready to eat, staff checked to see if their original option was still required. Staff acknowledged patient's choice both before and after surgery and alternatives were always available.

Pain relief

- All patients we spoke with were given advice after their surgery about pain relief and managing pain effectively. Patients were given prescribed pain relief to take home and this was ready for them on discharge.
- Patients were assessed for pain and staff recorded their score in the patients record at regular intervals throughout their recovery. We observed patients records and prescriptions indicating when pain relief was offered and administered appropriately.
- The service completed monthly patient pain assessment audits to monitor the effectiveness of pre- and post-operative assessments carried out by all theatre staff. Pain assessment standards and staff responses to patients with pain were measured. We observed completed audits of 100% compliance with pain assessment standards.

Patient outcomes

- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. The service used data to benchmark against other similar services nationally and within the HCA Healthcare organisation. Audit outcomes were monitored for effectiveness and reviewed monthly at the quality meeting.
- Patient outcomes were audited and reports showing trend analysis were reviewed through the internal governance structure. This included key performance indicators such as unplanned readmissions, unplanned returns to theatre, unplanned transfers out of the service, healthcare associated infections, significant incidents, and mortality.
- Data showed that between July 2017 and June 2018, there had been one unplanned return to theatre, one unplanned transfer to another hospital, two surgical site infections, no serious incidents and no unexpected deaths.
- The hospital had taken part in evaluating the long term outcomes of the management of atraumatic shoulder instability. This had shown, from a small cohort of patients, and improvement in the 'constant score' which is a clinical method of functional assessment of the shoulder. This was shown in the post-surgery and post-physiotherapy groups.
- The hospital had also taken part in a study of shoulder joint reconstruction surgery. All patients returned to their previous level of work and sports following reconstruction in a mean time of three months.
- Evidence of performance benchmarking against other HCA Healthcare UK locations was collated and discussed at the quarterly quality and safety review. We reviewed data of outcomes for the year ending December 2017 and the quarter two report (April to June 2018) which identified lessons learned and actions to improve practice. These included high impact interventions such as clinical documentation, risk assessments and key performance indicators.
- The hospital has introduced an electronic application, which provided patients with important pre and post-surgical care information, and demonstrated appropriate physiotherapy exercises corresponding to their surgery. It also collected pain and patient reported outcome measures (PROM's) data to better track patient outcomes. The hospital had 294 patients enrolled in the system with 54,335 exercise repetitions, 11,200 pain scores, and 705 feedback surveys logged.
- Feedback from patients about the arm clinic, showed 94% of patients felt they had improved. Approximately 22% of patients felt they had improved between 51% and 75% and 65% felt they had improved more than 75%.
- The hospital benchmarked safety performance such as falls and pressure ulcers against NHS services using the NHS safety thermometer. Up to year end December 2017 the hospital was within or better than recommended targets each month.

- The hospital developed a standardised observational audit schedule which was completed each month by all departments. Heads of service were responsible for collating the information and presenting the data at the service quality meeting. Any improvements were identified and addressed through departmental action plans.
- The hospital had been submitting data to the Private Healthcare Information Network (PHIN) since its inception. PHIN is an independent patient information network that informs and empowers patients to make informed choices about their care provider.
- The service carried out a patient satisfaction audit each month. Patients were encouraged to submit feedback on their experience with the service. There were locked boxes available in the department where patients could put their completed satisfaction questionnaires. Staff consistently received excellent positive feedback from patients. There were many responses named to the individual practitioner taking care of the patient.
- The service was developing plans for overnight stay beds if patients required further monitoring and support. This meant patients could remain overnight with the appropriate input rather than being transferred to another facility. The service had reported one transfer to the local provider between July 2017 – June 2018.

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 monitor the effectiveness of the service.
- The service monitored staff compliance and performance through monthly audits. The audits included staff awareness and understanding of a range of quality standards such as nutrition and hydration risks, falls, infection prevention and safeguarding.
- The service provided annual staff appraisals and had a compliance rate of 100% completion at the time of our inspection. Staff we spoke with had identified learning needs and were completing personalised performance plans following their appraisal. They told us the organisation core values formed the basis for their appraisal and helped to guide staff through their appraisal preparation.
- Staff with practicing privileges were offered access to the HCA healthcare appraisal process. The service had suitably qualified appraisers who were utilised to support staff who did not have access to appraisal. This meant staff had continuous support to identify learning needs and maintain competencies.
- The service had clinical facilitators who were available to support staff training and development. They monitored staff competencies and mandatory training compliance and kept staff informed with emails and newsletters. There were robust systems in place to monitor and develop staff practice. For example, a dedicated framework was developed for theatre staff to ensure staff were competent to deliver safe, effective quality care. We observed staff records with completed competencies and reflective summaries of their development.
- All staff were competent in basic life support skills. We spoke with staff who were trained in immediate life support and one member of staff who was trained to deliver advanced life support. Senior staff assured us that there was always a competent member of staff on duty to treat patients in cardiac arrest if required.
- We observed a notice board in the practitioner work area with information for staff such as duty of candour responsibilities, mental capacity assessment principles and health and safety. There were clear guidelines visible for staff to follow. Staff told us they always referred to the information for guidance when faced with an issue. Staff could also access information in the service electronic folders.
- Staff told us they had regular meetings to review safety processes and staff contributed to developing resources. Staff told us this kept them informed of the latest guidance and best practice. One example was given where a failing in some infection control techniques had resulted in staff developing clearer guidance for staff.
- Staff competencies were reviewed annually and a training needs analysis was developed for each profession in the service. The competency framework was used to determine the skill mix in the teams and was audited to ensure the appropriate number of competent staff were in place. Staff told us that as well as completing competencies relevant to their own role, they were aware of other professional competencies. This gave them a better understanding of the various tasks the staff in their team carried out and further developed their knowledge of their colleague's roles.

Good

Surgery

- We spoke with two new members of staff who were in the process of completing their induction programme. Staff had attended the corporate induction where they gained an overview of the service including the corporate vision and values and the expectations of staff joining the service. The induction programme covered all mandatory training and this was completed during the first week.

Multidisciplinary working

- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- The service demonstrated excellent teamwork through multidisciplinary daily safety huddles where all departments were represented. A variety of staff disciplines were involved in patient assessments and developing patient pathways. For example, we observed staff from physiotherapy, surgery, outpatients and housekeeping contributing to patient care to ensure holistic treatment and recovery.
- The hospital had identified a gap in effective multidisciplinary team (MDT) working with other organisations. Staff we spoke with told us they did not always gain feedback of onward referrals. In response the hospital carried out an audit of patients with cancer to monitor onward referrals and ensure they had followed the appropriate MDT pathway. We spoke with the senior management team who confirmed they were developing plans to increase MDT working across services.

Seven-day services

- The service operated six days a week between the hours of 6 am and 10 pm. The service remained open until the last patient had completed recovery. Outside of operating hours, there was 24-hour cover for patients via telephone and an on call registered medical officer based off site.
- The service had access to overnight beds where necessary and service level agreements in place with other organisations.

Health promotion

- The service held regular events to raise awareness of health and wellbeing for the local community.
- The nursing pre-operative assessment included nurses discussing patient's lifestyle and current health conditions and, if appropriate, recommending changes and providing appropriate information leaflets to patients. If leaflets were provided, this was recorded on the assessment so that other health professionals could follow this up on the patient journey through the service.
- All patients we spoke with told us they were given advice on ways to keep surgery sites clean and to observe for signs of infection.
- Staff told us patients with diabetes were given support and advice about dietary recommendations. Staff demonstrated awareness and advice given to patients with poor diabetic management such as the importance of monitoring blood sugars.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.
- The service developed pocket sized cards with information on mental capacity and consent. All staff carried these and referred to them when further guidance was needed. Staff we spoke with demonstrated a very good awareness of assessing a person's capacity to consent and the process to follow when they had any concerns.
- The service had a robust process for consent which was checked thoroughly and reviewed throughout the patient's pathway. This included signed forms explaining surgical procedures and a checklist for staff to ensure they had followed the appropriate process.
- The consent and capacity to consent to treatment policy contained guidance regarding Gillick competence assessments for children under the age of 18.

Are surgery services caring?

Good

We rated caring as **good.**

Compassionate care

Good

Surgery

- Feedback from patients who used the service and those close to them was continually positive about the way staff treated patients. We heard examples of when staff went the extra mile and their care and support exceeded patient's expectations.
- We observed and heard examples of patient and family feedback praising staff for their support and professionalism. We spoke with patients who praised staff for the way they demonstrated understanding and compassion. We reviewed audit data of the friends and family feedback that consistently demonstrated 100% positive feedback.
- Staff told us they were proud of the excellent rapport they could build with their patients and those close to them. Staff were allocated a patient on admission to the surgery department and remained their named practitioner throughout their stay. This gave staff the opportunity to get to know the patient and family. Staff told us they set times to contact patients they had been involved with post-surgery to see how they were recovering.
- Staff consistently demonstrated professionalism and competence in their roles. Patients told us they were constantly reassured by the staff depth of knowledge and were extremely confident in the staff looking after them. We observed an exceptional standard of expertise among staff and evidence of sharing knowledge within the team.
- One patient told us they had high expectations of the service as a recommended provider of private healthcare but they were surprised at how impressed they were. The service had far exceeded their expectations and they had no hesitation of recommending the service to others. The patient had referred a work colleague for a consultation following their discharge.
- One patient told us their primary reason for choosing the service was the staff expertise and knowledge. Three patients told us they had been recommended the service by friends and colleagues who had experienced excellent care and treatment.
- Patients told us of the relaxed and friendly attitude of consultants. All patients we spoke with told us the consultant sat with them after their surgery, explained everything about their procedure and checked to make sure they understood.
- A patient told us they had mentioned to staff they enjoyed a particular brand of ice cream. The service did not have this brand on site so whilst the patient was undergoing surgery, a member of staff went out to buy some. They gave the patient the ice cream after they had recovered from their surgery. The patient told us how impressed they were by this, particularly as they had only mentioned it during a short conversation.
- Staff told us when a patient celebrated a birthday during their admission to the service, they bought a birthday cake for the patient. When the patient was fully recovered, the staff presented them with the cake and sang happy birthday.
- Staff gave excellent examples of supporting relatives whilst the patient was in surgery such as escorting relatives to the shops as they were not familiar with the area. Staff told us of times where they had sourced hotel rooms for relatives to relieve them of the worry whilst the patient was in surgery.
- Relationships between people who used the service, those close to them and staff were caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders. The hospital quality and patient experience matron collated written feedback and fed this back to staff verbally, by email and in the hospital quality newsletter.

Emotional support

- Staff provided emotional support to patients to minimise their distress. Patients told us they were naturally anxious before surgery and staff constantly checked patients to ensure emotional needs were met.
- Staff told us how they assessed patient's emotional well-being as part of the preoperative assessments. This was reviewed throughout the patient's time with the service. Patients told us staff had a way of knowing they needed someone to talk to without having to ask.
- The service had access to a wide range of support for patient's emotional well-being. For example, there was a Macmillan nurse located at one of the sites locally who was easily accessible and could also provide support and advice remotely. The service had a highly skilled therapy team at another of their services in the region. Referrals could be made at short notice over the telephone or by email. As part of a wider organisation, there was access to services through many of the HCA Healthcare UK facilities.

- One patient told us of their severe anxiety before their surgery. Staff had responded calmly and helped to reduce the patient's anxiety by sitting with them. They explained the process in a way they understood which helped calm the patient significantly.

Understanding and involvement of patients and those close to them

- Staff involved patients and those close to them in decisions about their care and treatment. All patients were allocated a named practitioner prior to admission. Staff introduced themselves to their patient who was allocated on admission and remained their named practitioner throughout their stay in the department.
- We observed staff consistently involving patients in their care. Staff told us they aimed to anticipate patient requirements and those close to them to help mitigate any anxieties. For example, we heard of an example of one patients chaperone who had temporary mobility issues at the time of the patient's surgery. The staff identified this might have an impact on supporting the patient after their surgery. In response, staff considered this as part of the patient's treatment plan, ensuring their chaperone was fit to support the patient.
- Staff told us their relationship with patient families, friends and carers was an important part of their care for the patient. All staff emphasised the importance of individualising the patients care to involve those around them and told us this was important when supporting the patient's recovery.
- Patients told us their relatives were as well looked after as they were. Staff regularly contacted relatives and kept them updated on the patient's progress. Patients told us this had reassured them knowing their relative was being supported. Patient statements included "the staff are so tuned into you, they know what you need without even asking" and "the staff are amazing. They gave my husband support whilst I was in there and kept him informed through the morning".

Are surgery services responsive?

Good

We rated responsive as **good.**

Service delivery to meet the needs of local people

- The department offered a variety of specialities and interventions including orthopaedics, cosmetic surgery, ophthalmic, ear, nose and throat, plastic surgery, pain management and urology.
- There was a very high standard of patient pathways developed in collaboration with both private and NHS providers. These included pre- and post-operative support for patients and assurance that patients were referred to the most appropriate services if required. As part of a larger organisation the service had access to many specialisms as well as links with NHS and private services nationally. This meant there was a multi-disciplinary team available to patients as necessary.
- Patient pathways were also developed in collaboration with services such as private healthcare insurers with whom the service had been accredited. As a preferred provider of care, pathways were developed to ensure a seamless patient journey through the healthcare system. Diagnostics and treatment were carried out at the service and the patient was transferred to other services within the organisation where necessary. This provided excellent reassurance for the patient from admission to discharge.
- We spoke with patients who had travelled long distances for their procedures. The service considered patient distances from the location during the pre-operative assessment to ensure patients could access the service. They were offered the earliest theatre slots to help avoid traffic and could be discharged at a reasonable time later in the day. This reduced patient anxiety with travel arrangements and supported friends, relatives or carers escorting them.
- The service was developing systems to allow patients to remotely access pre-operative assessments. For example, some patients from overseas would be offered pre-operative assessments electronically saving them time and travelling unnecessarily. The service was developing a remote system to offer this.
- One patient told us they had completed a preoperative assessment over the telephone due to living a long way from the hospital. This meant they did not have to make multiple journeys to and from the hospital. Staff confirmed this was offered to patients who were assessed as appropriate for a telephone consultation.

Meeting people's individual needs

Good

Surgery

- We observed staff acknowledging patients' individual needs. We observed patient records of assessments where individual requirements were discussed and documented. Where patients required reasonable adjustments, this was flagged. There were also assessments of those escorting patients to ensure they had facilities in place to support them if required. For example, staff told us of a relative chaperoning a patient who had struggled with mobility. The service arranged for the assessment to be completed on one level of the building which alleviated the patient and their relative transferring from one area to another.
- The service had access to diagnostic services on site which meant any investigations could be carried out during the patient's admission if necessary. Staff gave us many examples where a consultant requested a diagnostic scan at short notice and the service could accommodate this.
- Patients told us staff had arranged scans to be carried out on the same day as attending the hospital. One patient told us the surgeon identified they would benefit from further treatment after their surgery. As the facility to carry out the treatment was already available on site, the procedure was carried out the same day. This meant the patient did not have to be discharged and return at a later date.
- As part of a wider organisation, the service could access specialist services locally and nationally if required. For example, there was a Macmillan nurse at one of the facilities locally who was easily accessible by telephone and visited the service as required. There was also a highly skilled therapy team at another of the corporate facilities in the region. Patients were referred to the team as part of their recovery and rehabilitation plan if required.
- The service had a separate family room where patient's relatives or carers could wait. As patients were being assessed there were adequate facilities for family members, friends or carers to wait.
- The service had access to interpreters who supported patients, relatives and carers with any language barriers or issues where required. Patients were informed of the availability in literature sent in the pre- assessment pack and interpreters could be arranged in advance of admission.
- There was a poster which provided information in different languages to patients explaining that information was available..
- All the concierge and reception desks at the Wilmslow Hospital had a short welcome message in braille. Information leaflets were available in braille and there was a hearing loop for patients who had hearing loss.
- We spoke with staff about their awareness and responsibilities for patients with special requirements such as patients living with a dementia illness. Staff told us they did not have many patients with a dementia illness but were familiar with the corporate policy on supporting patients. Staff reflected on their safeguarding training which incorporated dementia awareness and told us they had completed the corporate study sessions. The service had departmental dementia champions who were key contacts for information.
- We spoke with staff who were involved in patient pre-operative assessments. They told us they assessed patients using preoperative tests based on the complexity of the surgery following National Institute for Health and Care Excellence guidance. This included consideration of patients with dementia in relation to the type of surgery they required. A letter of explanation was sent to the referrer of patients who did not meet the referral criteria.

Access and flow

- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice. The service did not have a waiting list and access to the service was flexible to meet patient's needs.
- We spoke with patients who had been attending the service for several years and those who had visited for the first time. All patients told us they only had a short time to wait for their procedure; some were offered appointments within 24 hours following their assessment.
- There had been 51 cancellations of surgery by the service for non-clinical reasons between June 2017 and July 2018. All patients had been offered another appointment within 28 days of the cancelled appointment.

- Patients who did not or could not attend the hospital for their pre-operative assessment were sent swabs to check for potential bacteria such as Methicillin-resistant Staphylococcus aureus (MRSA). These were sent through the post and patients could return these once completed. This meant patients did not have to re attend the hospital more times than necessary.
- The service accepted patients locally and from overseas. As part of a larger organisation patients had access to a variety of specialist services within the organisation. For example, following on from orthopaedic surgery, patients could access the specialist physiotherapy services locally for rehabilitation and support.
- Theatre staff remained on site until the patient was appropriately recovered. Patients were usually admitted to theatre no later than 4 pm. The service had access to overnight beds at another facility in the event of patients requiring an overnight stay. Whilst it was rare for patients to need an overnight stay, some surgeons preferred to monitor their patients for safety and reassurance.
- The service was developing plans for an overnight stay facility on site and a business case had been submitted. This meant patients could be safely admitted and remain overnight rather than being transferred to another facility.
- The service had developed effective pathways to monitor patients who had been referred on to other services. For example, some patients who had been identified as having a progressive illness were closely monitored to ensure they followed the most appropriate patient pathway. Staff told us they sought assurance from the receiving services to ensure the patient was assessed by the appropriate multidisciplinary team.

Learning from complaints and concerns

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. Patients received written information on how to make a complaint in their preoperative assessment pack.
- Staff demonstrated a proactive approach to continuous learning from complaints and concerns. Staff told us they managed most patient or family members concerns at the time they were raised. Most could be dealt with easily and amicably due to the professional relationship staff had built with patients. Staff told us they were confident patients felt able to discuss concerns freely.
- Staff gave patients and their relatives or carers information on how to raise any concerns. There were leaflets informing patients how to make a formal complaint available in various areas of the hospital. Patients told us they received literature on how to make a complaint in their pre-operative information packs.
- There were two formal complaints received in surgery. These were addressed through the service complaints process and both resolved. The policy was to respond to formal complaints within 20 working days; if the complaint was complex, the complainant was written to informing them of the delay and providing a date of expected completion.
- We observed a detailed action plan for formal complaints the service had received. There was evidence of honesty and transparency in the responses and appropriate staff involved in dealing with each complaint.
- There was a very strong staff culture of ensuring patient satisfaction across the service. Staff told us their response to complaints or concerns was always to understand and value the patients experience.
- When responding to formal complaints the service was open and transparent. They provided a full explanation to patients, relatives and carers as necessary. All staff who had been involved in the formal complaints process were aware of their duty of candour responsibilities.

Are surgery services well-led?

Outstanding ☆

We rated well-led as **outstanding.**

Leadership

- Managers at all levels in the service demonstrated a high degree of skill and ability to run a service providing high-quality person-centred care.
- There was a very well established, proactive senior management team which included a regional chief nursing officer, regional director, chief governance and

risk officer, finance officer and human resources officer. There was clear evidence that the senior management team supported and encouraged staff across the service.

- The chief executive officer had overall accountability for the services provided at the hospital. We saw that operational responsibility was split between the regional chief nursing officer (who was primarily responsible for the provision of care) and the chief governance and risk officer (who was primarily responsible for governance).
- The hospital was led by the general manager who had the right skills and abilities to run the service providing high-quality sustainable care. The general manager was supported by the senior leadership team who had a regular presence at the hospital. Staff told us there were senior management on site daily and regularly attended the department to speak with staff. There was visible and proactive leadership and all staff we spoke with told us who their management team were and their role within the organisation
- There was an encouraging approach to development and succession planning which aimed to ensure that the leadership represented the diversity of the workforce. For example, the hospital gave staff the opportunity to work towards an accredited leadership qualification if they expressed an interest to become future leaders in the organisation.

Vision and strategy

- The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups. The vision for the hospital was "exceptional people, exceptional care".
- As part of the wider HCA healthcare organisation, there was a corporate mission and values statement that was shared across all its services. The statement was "above all else, we are committed to the care and improvement if human life. In the recognition of this commitment, we strive to deliver high quality, cost- effective healthcare in the communities we serve". It was evident that senior managers set the standard for staff by representing the service values and demonstrated their understanding of the organisation strategy.
- The mission statement was underpinned by four value statements and a code of conduct, of which were embedded in the appraisal documentation.
- Staff we spoke with were very clear on the service vision and strategic framework.
- The service offered regular briefings to staff through meetings and email updates. Staff also told us they had been asked to contribute to the service strategy with ideas about its future, particularly with regards to patient outcomes and experience.
- Staff told us the service vision and values formed the structure of staff appraisals and were embedded in all activities they carried out. Staff were passionate about the service and believed their approach to care was consistently in line with the service vision and values. We saw and heard many examples of this in practice.
- The service had a clear quality framework which outlined the service strategy for the coming years. There was a clear focus on patient safety and quality care which was shared by all staff we spoke with. The strategy was achievable and we observed innovative systems being developed to support this. This included development of the breast care service, plans to develop an overnight bed service and the full integration of the nursing strategy across all HCA Healthcare UK services.
- The service had a nursing strategy in place to improve the quality of nursing in all areas of the service. The strategy was being developed across all sites and included plans to monitor and improve performance through staff competencies and training. The nursing strategy aimed to develop staff leadership skills through relevant training courses and we spoke with staff who were about to commence training.
- Nurse staffing had improved since August 2016; data provided by the hospital showed improved sickness and turnover rates in August 2018. Senior managers were working in line with the nursing strategy to ensure staff were supported and motivated to deliver high quality care. We reviewed the nursing strategy that included leadership actions such as Band 6 development programme, effective ward managers training and coaching opportunities. Staff we spoke with across the hospital said they had received mentoring, leadership training and quality discussions about career progression.

Culture

Good

Surgery

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff, were actively encouraged to provide to their views on departmental plans, service development and departmental objectives. The aim of this was to integrate this information into staff performance plans and appraisals.
- The hospital conducted annual staff survey which showed 88% of staff felt trusted to do their job. Senior managers advised that they welcomed suggestions from staff on how to support them.
- There was a very strong culture of staff feeling confident to challenge practice. All staff told us they received a positive response and there was always two-way dialogue between practitioners. All staff spoke highly of the positive culture within the service. Staff told us of the 'family' atmosphere among the team and everyone worked together to benefit patients.
- We spoke with staff who told us there had been vast improvements in staffing over the past two years. Prior to this the service had used a high number of agency staff and staff felt unsettled. Many agency staff had become permanent members of the team and gave positive accounts of their experience working with the service.
- We spoke with a member of staff who had been with the service for many years and travelled forty miles daily to work at the service. They told us they had not considered a position closer to home as they were very happy in their role. They could not imagine a job elsewhere they were able to deliver such high-quality care and work with such an expert team.
- We observed senior managers demonstrate a supportive and proactive attitude towards staff and the service they provided. This had a direct, positive impact on the way staff in the service worked together through consistent engagement and visibility.
- We observed team safety huddles where all services were represented and all staff had a voice. Senior staff told us they listened to all staff as everyone had a crucial role to play in providing quality care.
- The service offered regular staff listening events led by senior managers where staff could raise concerns or issues. All staff we spoke with were confident raising any issues at the event and felt decisions were discussed openly and fairly.
- The hospital had undertaken work on equality and diversity as part of the corporate work stream. Mandatory diversity management training, incorporating cross-cultural communication and inclusive leadership, was attended annually by the leadership team and heads of department.

Governance

- The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.
- We observed a highly established and effective governance structure. Heads of service, senior managers and the chief executive shared the organisations vision of quality and this was embedded in staff engagement throughout the service.
- The facility governance meetings held at the hospital was a platform for the senior management team to discuss the strategic framework and regulatory compliance. The format of this meeting was split into four domains: safe, effective, caring, responsive and well led so that it mirrored the regulators framework. For example, in the safe section managers reviewed an incident whereby theatre staff discovered their unconscious patient did not have a wristband on. The patient was checked and a name band was placed on the patient. Minutes showed that a review was underway to understand the breakdown in the process and managers were awaiting this to be completed.
- The heads of each department met monthly at the regional professional clinical forum where they presented a report of their service. This was used as an opportunity to share learning, good practice and address any performance issues. Staff told us they found the forum effective where they could meet with their peers across the region and share experiences. Issues from this forum were escalated by the chief nursing officer to the quality and governance meeting.
- The service benchmarked itself both internally and against the NHS, were possible. This data was reviewed at the company wide Quarterly Quality and Safety meeting.
- The hospital had implemented monthly 'matron assurance rounds'. This meant a senior clinical person evaluated all methods of data collection including audits, training reports, incident trends and patient satisfaction to provide an overall picture of a clinical area. The matron visited the clinical areas to inspect the

quality of standards ensuring that the data was reflective of practice. Compliance was reported against the five CQC domains of safe, effective, caring, responsive and well-led. The matron then worked with the clinical leaders to formulate objectives and plans to further improve practice.

- The hospital had a comprehensive system in place to monitor practising privileges. Consultant information including General Medical Council registration, appraisals, indemnity insurance, and disclosure and barring service checks was on the hospital system and was available to the general manager. The hospital had recently introduced an automated reminder system that emailed consultants in advance of the expiry of certain information.
- The medical advisory committee met quarterly and covered all departments across the region. We reviewed the minutes to this meeting which showed detailed discussions of performance, learning and practicing privileges. The meetings were sub divided into specialist areas and each head of department presented their report. The meetings were well attended, we saw evidence of multi-disciplinary representation at the committee.
- The medical advisory committee reviewed each consultant that held practising privileges every year to ensure that their private work conducted at the hospital has been discussed with their NHS responsible officer. Evidence of practice and appraisal was reviewed by the committee and the company's medical director.
- We spoke with the medical governance lead who had a clear understanding of the service vision and strategy. They told us of the robust structure of the medical advisory committee and how the service was proactive in maintaining high quality care. There was a robust system in place to assess the suitability of staff applying for practicing privileges with the service which included a rationale for wanting to work with the service, current competencies and distance from the location.
- Staff who had experienced working with other services spoke highly of the governance structure of the service. Staff told us the service was very well managed and actions identified through committees and governance groups were completed in a timely manner.

Managing risks, issues and performance

- The service had systems in place to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected. There was a robust quality and governance framework which supported the governance team in their decision making.
- The service was proactive in ensuring patient safety and maintaining quality care. Monthly quality and governance meetings were established to review risks, incidents and performance. Local guidelines were followed and reviewed to ensure patient safety and mitigate future risks. Full discussion took place where incidents could have been avoided and a review of the service protocols took place.
- The hospital conducted a programme of internal audits to ensure that all services were providing a quality service. The audit programme set out the frequency of audits including hand hygiene, medical records and the surgical safety checklist.There was a full audit plan for the year which highlighted those that had been completed and those that were pending. Audits were discussed at the facility governance meeting to highlight any concerns or areas of improvements.
- The results of the audits and patient satisfaction surveys were discussed at monthly audit accountability meetings. The meeting was chaired by the matron for quality and patient experience. Each department was represented and the matron for hospital attended. Each department presented their audit results and accounted for any areas of low compliance. The patient satisfaction survey results were also reviewed. The findings of these reports were used to evaluate the success of previous improvement plans and to plan the next improvement cycle. Outcomes from the audit accountability minutes and patient satisfaction surveys were reported into the monthly governance meeting.
- The service actively submitted incident reports to the care quality commission (CQC) where they felt lessons could be learned from the event. This was followed up with a report of their incident analysis and action plans. We observed not all incidents were high level but the senior management team recognised there were lessons to be learned. All risks and incidents were discussed at the professional clinical forum and local operational meetings where all heads of department and senor clinicians attended. There was a robust system for reviewing incidents and re assessment of the level of harm.

- The medical governance lead told us of risks that had been identified and how the team reviewed these to ensure potential lessons were not missed. For example, incidents that had been graded as low or no harm were scrutinised to establish whether any lessons may have been missed.
- The hospital's risk register was closely monitored to ensure systems were in place reviewed and mitigated risks. We reviewed action plans to address risks which identified clear systems in place to mitigate the risks. For example, patient onward referrals and assessment by an appropriate multidisciplinary team was identified as a risk to patient safety. This was being addressed and actions put in place to identify best practice pathways were followed. The hospital carried out a recent audit to monitor onward referrals for patients with cancer and identified an improvement in multidisciplinary team involvement following the actions that had been implemented.
- The heads of all departments attended the monthly quality meeting where patient outcomes were discussed and any areas of improvement could be addressed. The heads of each department presented data from the patient satisfaction surveys.
- There was a governance message of the week shared with staff. We saw an example regarding information governance, which was shared following incidents at other locations.

Managing information

- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service collated detailed information and benchmarked against other hospitals. There was a commitment at all levels to sharing data and information proactively to drive and support continuous improvement.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. Patient records we reviewed were of a good comprehensive standard. In conjunction with electronic reporting of test results, staff told us they had all the information needed to provide safe care and treatment.
- In response to patient satisfaction survey results, the service identified further ways to make the feedback process simpler and more effective. The service had plans in place to develop an electronic system located in patient's recovery rooms to leave feedback. This meant patients could complete feedback in their own time at the bedside and the service could monitor and act on patient responses.
- The service had a Caldicott guardian in post who was responsible for ensuring patient confidential information was protected and ensured this was managed appropriately. The service used an electronic system for storing patient information and paper documents which were scanned onto the system. All patient confidential information kept electronically was password protected and paper documents were secured in locked facilities on site and away from public accessible areas.

Engagement

- The service engaged well with patients, staff, and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- Staff told us they were proud to be involved with the local community. The service supported local charities and sponsored competitions as well as holding regular events to raise awareness of health and wellbeing for the local community.
- The chief nursing officer held regular formal and informal employee meetings with the heads of each department to discuss performance and the delivery of the service. Staff told us they found the chief nursing officer was always approachable and met with staff regularly.
- Staff told us of the "you said, we did" events which were an opportunity to engage with staff where they could identify areas of excellence and raise any concerns. Staff gave us many examples of areas of discussion and all staff we spoke with felt involved.
- There was a staff engagement champion who arranged regular events which included quizzes, coffee events and a staff 'star of the month' award. The monthly staff star award was presented to a member of staff who had been recognised for their contribution to care. This was open to all staff across the service. Events were published in the service newsletter which was circulated electronically to all staff.
- The service offered continuous education sessions to staff and GPs in the region. Invitations were sent informing staff of upcoming events and were free to attend. Specialist consultants delivered a range of

educational sessions and specialist talks aimed at improving practice. Topics included orthopaedic, neuro surgery and gastroenterology. Were viewed highly positive feedback comments following one of the sessions.

Learning, continuous improvement and innovation

- The service was committed to improving services by learning from when things went well or when things went wrong, promoting training, research and innovation.
- The service had a comprehensive learning lessons framework aimed at developing and maintaining a positive culture in learning from incidents. The framework supported staff by highlighting the importance of reporting when things go wrong and learning through a systematic approach. We observed clear evidence of staff understanding and importance of learning from incidents.
- The service had developed a unique electronic application to assist with recovery and rehabilitation post-surgery. The physiotherapy application had been initiated by a team practicing at the service and they had developed a series of exercises and comprehensive, easy to follow information. All patients undergoing surgery that required some form of rehabilitation were invited to download the free application. We spoke with a member of staff who had used the application. They spoke highly of its benefits with recovery from surgery and post-operative rehabilitation.
- The service was developing a professional practice council led by the deputy chief nurse, this forum was going to be used to discuss evidence-based practice and standards so that managers could ensure all future changes to polices was discussed through this council. The primary focus of the council was to support the nursing strategy, giving nurses a strong professional voice and autonomy to improve patient care. Best practice was identified and implemented through quality nursing care, clinical practice, reviewing patient satisfaction and standardising policies and procedures.
- The service developed a campaign raising staff awareness of safety messages and different types of avoidable incidents to ensure patients were kept safe. This was in response to local and national reports of promoting a culture of patient safety. The 'keep me safe' campaign identified incidents and emerging themes around patient safety. Staff told us they had received feedback from incidents and were involved in lessons learned.
- The Arm Clinic at the Wilmslow Hospital had published research regarding the outcome of the care and treatment delivered at the Wilmslow Hospital. In order to develop this research programme further, to include broader hospital patient outcomes a research task and finish group was established in December 2018. The group had met on a bi-monthly basis to discuss the objectives. This group has established links with local universities.

Outstanding ☆

Outpatients

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

Are outpatients services safe?

Good

We rated safe as **good.**

Mandatory training

- Staff had received up-to-date training in all safety systems, processes and practices.
- All staff had received mandatory training at the time of inspection. Staff we spoke with confirmed they had enough time to complete mandatory training.
- Mandatory Modules included basic life support, equality and diversity, ethics and code of conduct, fire safety, health and safety, infection control, information governance, safeguarding adult's levels one and two and safeguarding children levels one and two.
- The general manager monitored mandatory training for resident medical officers (RMO's). RMO's had completed 100% of their mandatory training.

Safeguarding

- The service had comprehensive systems and processes in place to keep patients safe, which took into account current best practice. All safeguarding processes were underpinned by the safeguarding policy for children and young people and safeguarding adults at risk. It contained reference to a range of topics including female genital mutilation (FGM), domestic abuse and neglect. It also detailed the pathway in for staff to report a safeguarding incident or concern.
- All staff in the outpatient's department were engaged in reviewing and improving safety and safeguarding systems. They had an excellent understanding of safeguarding. They gave several examples of what constituted as a safeguarding concern and spoke about when they had been involved in a safeguarding concern. They were all able to describe the safeguarding processes seamlessly and were conversant with who the safeguarding lead was (the regional chief nursing officer - trained to level four) and how to escalate the concern to the safeguarding team.
- We found there were safeguarding systems in place to protect patients from harm and abuse. The service reported all staff had completed mandatory safeguarding training levels one and two for children and young people and for adults at risk.
- There were arrangements in place to identify safeguards on the electronic system. The patient record prompted staff to complete a safeguard assessment. This was a mandatory field and required staff to complete before they moved on.
- All staff were familiar with the safeguarding 'app'. This was available for staff to log into via the intranet; we reviewed the app, it contained information on topics such as different types of abuse, how to report a safeguarding concern and consent.
- A process was in place to signpost women to national domestic violence helpline to avoid risk of the perpetrator becoming aware that the victim had sought support.

- Staff we spoke with told us they safeguarded any child who did not attend their appointment. This was incident reported and reviewed by the safeguarding lead.

Cleanliness, infection control and hygiene

- Staff we spoke with were familiar with the hospital's infection prevention and control (IPC) policy to ensure correct procedures were followed to prevent cross contamination.
- All staff we observed adhered to the policy including bare below elbows and washing hands between patient contact.
- The service reported 100% of staff had attended mandatory IPC training at the time of the inspection.
- Staff told us patients who had been identified with any infection control risk were allocated an appointment at the end of the day. This meant the risk of cross infection to other patients was reduced and the area could be deep cleaned afterwards with the appropriate cleaning materials. Areas requiring deep cleaning were not used again until the following day.
- Comprehensive monthly audits of infection prevention and control evaluated environmental cleanliness and hand hygiene. Data showed all areas were 100% compliant.
- The service completed regular water safety checks in line with the Control of Substances Hazardous to Health Regulations 2002 to ensure risk assessments and control measures were in place to prevent or control the risk of bacteria like Legionella bacteria in the water system.
- There were appropriate systems in place for the storage and disposal of clinical waste. Waste was segregated, labelled and dated and stored in the dirty sluice.
- Minutes from IPC committee meetings between July 2017 and November 2017 showed attendees discussed a range of areas including sepsis, flu vaccination programme, water report and new guidance.
- There were systems in place to prevent healthcare associated infections. All areas across the outpatient's department was 365 days free from MRSA and Clostridium difficile (C-difficile).
- All clinical areas had soap dispensers, hot and cold running water and paper towel dispensers. Consulting rooms had antibacterial rub dispenser and these were also located at intervals on the corridors and in the patient waiting area.
- We observed all dispensers were clean and full of the relevant product. There was also hand hygiene guidance located at each sink with diagrams of effective hand hygiene.
- There were dispensers for aprons and gloves in small, medium and large sizes located in all clinical areas. This meant staff could easily access the appropriate personal protective equipment as required.

Environment and equipment

- Resuscitation trolleys across the department were checked daily by a designated person and a log book was signed after each check. Checks were made on equipment and consumables on the trolley to ensure they were fit for use. For example, the defibrillator was checked and the trace recording was recorded. The trolley was tagged with yellow tags dated to indicate that all items had been checked.
- There were labels on each of the curtains indicating when they were last replaced. We observed curtains had recently been changed. Staff told us these were monitored monthly as part of the cleaning schedule and replaced when required.
- There were service level agreements in place for the maintenance of equipment. All technical issues were reported on a reporting system and prioritised according to the impact of the broken item. Staff would then receive an email to confirm the item had been fixed.
- All consultation rooms had adequate and appropriate equipment in the department to carry out the treatments at the time of inspection. Staff told us they had access to any specialist items if they needed them.

- Staff were responsible for maintaining the equipment in the clinical area, weekly stock checks across all consultant and treatment rooms were complete. We saw actions on check lists that had been addressed by staff in the previous weeks.
- There were sufficient arrangements for managing waste and clinical specimens. For example, sharp implements, clinical waste were discarded in the appropriate containers and stored in locked cupboards located away from the clinical areas. These were not accessible to anyone without the appropriate access.

Assessing and responding to patient risk

- The service had a proactive approach to anticipating and managing risks to people who use the service and was embedded and recognised as the responsibility of all staff. For example, outpatient staff discussed patient risks at the morning and afternoon handover. This meant staff could put actions in place in readiness of any anticipated risks.
- There were comprehensive risk assessments carried out on patients who used the service. For example, we saw a deteriorating patient transfer pathway in place for patients who became clinically unwell and required hospital admission.
- There were clear pathways and processes to assess patients who were clinically unwell or those requiring urgent medical intervention.
- There were processes in place to support patients being transferred into local NHS or other hospitals. All doctors were required to have a Service Level Agreement's (SLA's) in place with a receiving hospital so they could transfer their patient if necessary.
- Emergency pull cords were available in changing rooms, toilets and pre- assessment areas. Staff could communicate with patients via the intercom whilst they were in the scanner to ensure they were well. Patients were also given a handheld alarm which was audible in the control room and used to alert staff if they felt unwell or wanted the scan to stop.
- The hospital had a clear process for assessing and responding to a deteriorating patient. Two nurses carried the 'crash' bleep (these were first and second responders), a runner and a time keeper. We saw documentation that evidenced that staff had participated in a simulated emergency exercise in September 2018 to ensure everyone knew their roles and responsibilities. During the morning safety huddles, names of the crash team were given to staff as this changed daily.
- When the service treated children, staff had access to a registered children's nurse that could provide advice always.
- We saw that the service had provisions in place to manage a deteriorating child. All areas had paediatric resuscitation equipment, in case of paediatric emergency. All staff were paediatric basic life support trained and two staff were paediatric advanced life support trained.

Nursing staffing

- The outpatients services had systems and processes in place to provide the required nurse staffing levels so that patients were kept safe
- We saw no concerns relating to staffing, staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment always. It was evident from rotas that clinics were adequately staffed.
- There were approximately 5.8 whole time equivalent (WTE) nurses and approximately 1.8WTE healthcare assistants across the outpatient's department.
- The department used bank staff to cover shifts when required. Bank staff were booked from one, regularly used recruitment company. All staff attended local induction and were asked to adhere to all HCA's polices.
- The service reported having no unfilled shifts between May – July 2018.
- Staff sickness data supplied by the hospital combined outpatients and diagnostic data. Sickness rates fluctuated between August 2017 – July 2018, the highest percentage of sickness was reported in January 2018 (20%), figures reduced between 0%-5% between March - July 2018. The department displayed

expected and actual staffing levels on notice boards in each area we inspected and these were updated daily. We saw that actual staffing mirrored planned staffing at the time of inspection.

- Staffing was reviewed twice daily to evaluate any issues relating to staffing. Any concerns were escalated to the General Manager and regional chief nursing officer.
- The matron told us staffing levels were based on the number of clinics and this was reviewed to make sure there were enough chaperones and enough staff to cover all clinics.

Medical staffing

- The areas we inspected had sufficient numbers of medical staff with an appropriate skill mix to ensure that patients were safe and received the right level of care.
- There was appropriate on-site medical cover for the outpatients' department. The hospital employed two resident medical officers (RMO), who worked 12 hours a day. The resident medical officers scheduling was managed through an external organisation. They were asked to adhere to the European Working Time Directive and were not allowed to work more than 12 hours.
- Consultants provided treatment through practising privileges (authority granted to a physician by a hospital governing board to provide patient care). Practising privileges were monitored by the Medical Advisory committee, any concerns, including competencies, raised about consultants were dealt with through the 'Responding to concerns' policy via a Local Decision-Making Group and then the Corporate Decision Making Group if required.
- The Medical Advisory Committee had representation from consultants of all specialities this provided a multidisciplinary team approach.
- The Committee reviewed and monitored all consultant competencies and scope of practice to avoid any consultants working out of practice. The hospital reported none of the consultants had their practising privileges removed during the past 12 months.
- The CEO through the Centralised Credentialing and Registration Service based within the Corporate Office, with the oversight of the Medical Advisory Committee reviewed practising privileges annually.
- Where locum or agency doctors were used, the hospital requested assurances such as evidence of completed mandatory and safeguarding training prior to the doctor commencing work at the hospital.

Emergency awareness and training

- The hospital had backup generators so that continuity of treatment was ensured.
- The clinic had a business continuity policy that covered events including fire safety.
- The service took part in a comprehensive emergency simulation activity in September 2018, another one was planned for 2019. These sessions were in place to ensure all staff knew their roles and responsibilities in an emergency. We saw the session was well documented so that all staff could read it and reflect.

Records

- There were systems to manage and share information that was needed to deliver effective care and treatment.
- The department followed the corporate health records' management policy. The policy was in date and had a review date.
  - The hospital used paper-based records at booking and these were then transferred on to the electronic system.
  - Administration staff were responsible for the preparation of records, they checked patient's details when they booked in. Staff we spoke with told us it was unusual for records to go missing, but if they did they followed processes that included reporting the missing record as an incident. At the time of the inspection the service had not reported any missing records.
  - We reviewed five sets of patient records which were completed with details of the patients' name, date of birth, address, medical history and treatment plan.
- Records we reviewed held all the information needed to deliver safe care and treatment. Staff we spoke with told us records were available to the relevant staff in a timely

and accessible way. For example, test results and imaging results were retrieved easily by clinicians and risk assessments were electronically scanned into the patients' records.

Medicines

- Staff met good practice standards in relation to national guidance and they also contributed to the development of regional processes through the local intelligence network for medicines governance.
- All medicines and medicines related stationary was managed appropriately. For example, they were ordered, stored and managed safely.
- The department did not store controlled drugs.
- The pharmacy team visited the department daily, we saw that medicines were reconciled in line with current national guidelines. For example, we saw that documentation matched the amount of medication in cupboards.
- All staff had access to the British National Formulary for adults and children on the intranet. The app contained information and advice on prescribing and pharmacology.
- Staff recorded fridge temperatures across all areas daily. We found no errors in the information reviewed. We saw that there was a clear process that staff followed if the fridge temperature was not in the specified range.
- The resuscitation trolleys held medicines for use in resuscitation and treatment of anaphylaxis. These medicines were stored in tamper evident containers. Documentation showed that the expiry date, quantity and batch number of these medicines had been checked by staff.
- The pharmacy lead attended governance meetings to discuss incidents, learning and operational concerns; topics such as staffing, supply issues and resources was discussed.

Incidents

- There was a genuine open culture in which all safety concerns raised by staff and patients who used the service were highly valued as being integral to leaning and improving. We saw that staff had high regard to safety and all staff we spoke with told us learning from incidents was essential to improving patient care.
- The level and quality of incident reporting we reviewed incidents showed detailed summary of the level of harm, who was involved, what happened and why it occurred. We saw that the ward manager had reviewed all incidents. Staff told us, managers preferred this so that they could ascertain a full picture of the incident. Lessons learnt from incidents were shared with staff at weekly team meetings, through governance bulletins and the staff news board located in the staff room.
- Incidents were reported using an electronic reporting system, learning was based on a thorough analysis and investigation of what went wrong. All staff were encouraged to participate in learning to improve safety as much as possible, including participating in local audits, attending national and local training and working with others.
- There had been no serious incidents requiring investigation between the data period August 2017 to July 2018.
- The service reported 58 clinical incidents between July 2017 and July 2018 and 17 non- clinical incidents during the same data period.
- All staff were familiar with the term 'duty of candour' (the regulation introduced for all NHS bodies in November 2014, meaning they should act in an open and transparent way in relation to care and treatment provided). We did not review any incidents involving the duty of candour but staff gave examples of when duty of candour was exercised and the process they followed.
- The service reported no never events in the reporting period of July 2017– July 2018. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

- The hospital took part in the "The Keep Me safe" campaign in Summer 2018 to raise awareness of the different types of avoidable incidents. The purpose behind the campaign was to instigate a process of reflection and thereby help to reduce any such incidents happening in future. This campaign was in line with the lessons learnt framework and supported the openness and transparency charter.

Are outpatients services effective?

We do not rate effective in outpatients.

Evidence-based care and treatment (medical care specific only)

- Guidance from the National Institute of Health and Care Excellence (NICE) and Royal Colleges was disseminated to appropriate specialities and divisions. For example, we saw venous thromboembolism prophylaxis for adult's guidelines.
- Managers updated staff when new guidelines were introduced, staff were expected to sign to confirm understanding and application. We saw this was followed by staff when the service introduced policies.
- We saw a range of standard operating procedures for staff to follow. For example, staff followed the pre-operative procedures if patients came into clinic following a surgical procedure.
- Many policies and procedures were in place, and could be accessed via the intranet. Staff were aware of how they could access them across both systems they used. Staff showed us how to retrieve policies such as cardiopulmonary corporate UK policy.

Nutrition and hydration

- Drinks machines, water fountains and snacks were available free of charge, patients and relatives could make hot and cold drinks, whilst in the waiting area.

Pain relief

- Staff tried to make patients as comfortable as possible during their time in the department
- Pain relief was not administered by the service.

Patient outcomes

- The service had a comprehensive audit programme, this was designated to local, regional, and corporate audits. These were aligned to evidence based practice and national guidance.
- The service regularly reviewed the effectiveness of care and treatment through local audits. A range of data at both local and national levels was collected, so that managers could monitor and benchmark against other hospitals in the HCA Healthcare UK (HCA) group. We saw that audit results were reviewed monthly at local level meetings to ensure actions were implemented and in some cases re-audited for effectiveness.
- Additionally, all comparative data was available via the clinical information portal; the information was discussed at the Quarterly Quality and Safety Review Board which supported companywide, national and international benchmarking.
- The Monthly Clinical Operating Report consisted of operational data including patient experience and incidents. We saw that the senior management team monitored, discussed and reviewed monthly quality data, audit outcomes, risks and key performance indicators. The report was used to direct improvements to patient care.

Competent staff

- We saw that staff were supported to continuously develop their skills, competencies and knowledge to ensure they delivered high quality care. There was a strong focus on career progression within the department. For example, staff had recently commenced courses such as the pre-operative course in anticipation of extending the women's health services.
- Staff learning needs were identified through annual appraisal and the six-monthly review. Hospital data showed that all staff had received their annual appraisal at the time of inspection. The six-monthly review gave opportunity to revisit any plans made at the annual appraisal. This also meant staff were able to make changes to any professional development plans.
- New staff attended a corporate induction in London where topics such as HCA values and vision and the

business ethos was discussed. A local induction was carried out by the ward manager or matron, this included a tour of the hospital, introductions to the teams, demonstrations of equipment and location of fire exits and resuscitation trolley.

- We reviewed starter packs, these were extensive and informative of HCA's processes and policies. They also evidenced that staff had been shown equipment, completed the tour and signed that they read certain policies. Newly qualified nurses received a period of supernumerary status until they had their competencies signed off by the ward manager.
- We reviewed competency assessment folders from three members of staff. These contained specific competency frameworks that required the ward manager or matron to verify the staff member was competent to carry out a procedure. These had all been completed appropriately.
- Resident medical officers employed by Healthcare UK (HCA) completed a corporate and clinical induction. They were also asked to complete a local induction, so that they were familiar with the facility.
- The Medical Advisory Committee approved consultant practising privileges. Applicants submitted a practising privileges application form and provided the relevant supporting documentation such as a copy of their annual appraisal and evidence of revalidation with the General Medical Council. They then attended their first interview with the hospital Chief Operation Officer to acquaint themselves. The annual reviews for consultant practice and privileges was done by the Chief Operations Officer.

Multidisciplinary working

- There was evidence of strong multi-disciplinary team (MDT) working at the hospital.
- An audit was carried out by the hospital in 2018 to check if all patients diagnosed with a cancer in the hospital had gone through a multi-disciplinary team meeting. This was to ensure that all patients who had received a diagnosis of cancer were seen in an MDT meeting even if they were no longer a patient at the hospital.. The results showed all patients had. Senior staff we spoke with said they were working to increase MDT activity so that patients received the best care.
- Staff 'huddles' were carried out daily to ensure all staff had information about risks and concerns before the clinics started.
- We saw that outpatients and imaging worked closely together to provide the one stop women's clinic, staff coordinated appointments to ensure there was no impact on patients.
- When the service treated children, staff had access to a registered children's nurse that provided care.

Seven-day services

- The service did not offer a seven-day service, the hospital was opened six days a week. All activity stopped when the hospital was closed.
- Patients who had any concerns after they had left the hospital had access to a 24-hour care line, calls were answered by nursing staff, who gave the most appropriate advice.

Health Promotion

- Staff were aware of health promotion, they directed us to leaflets that could be given to patients if they approached staff about improving their lifestyle choices.
- However, there was limited information displayed about health promotion and there was no evidence of work being done to incorporate health promotion advice in clinics.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had access to the corporate consent and capacity to consent to treatment policy, this was in date and had a review date.
- Information for minor procedures was provided to patients prior to clinic so that they had the opportunity to read and sign before attending for their appointment. The information was discussed again at clinic and consent was checked by the consultant before the procedure began. This ensured that consent was given and it gave the patient the option to withdraw consent before the procedure commenced.

Outstanding ☆

Outpatients

- Data showed that at the time of inspection, 100% of outpatient staff, including medical staff, had received training in the Mental Capacity Act.
- In all consultations we observed staff requested verbal consent from patient's before carrying out any procedures. Consent was confirmed on the day of treatment and recorded in the patient record. In all the records we reviewed we saw that written consent had been obtained for procedures and treatments.
- Due to the type of service staff we spoke with said they rarely encountered patients who lacked capacity. Through discussions it was apparent that staff had a sound understanding of the Mental Capacity Act. They were aware of the process for assessing patients who lacked capacity and could describe the consent process for a patient who lacked capacity.
- We found staff carried mental capacity information cards that detailed the process of how to assess, record and discuss mental capacity.
- When children were seen, staff told us they used the Gillick competency framework to assess whether a child had the maturity to make their own decisions.

Are outpatients services caring?

Outstanding ☆

We rated caring as **outstanding.**

Compassionate care

- Patients were treated with respect and dignity and valued as individuals in the outpatient department. We saw excellent interactions between patients and all staff we observed. Interactions were appropriate and at times jovial and warming.
- Staff responded to patients in a compassionate, timely and appropriate way when they were experiencing emotional distress. We heard of examples where staff helped "mummy" tell her children that she had a breast lump. Families were taken in a quiet room, where mummy or the nurse could read a story book about mummy's lump. The book described feelings, the loss of hair and the impact on the family. Consultations were extended so that the family had as much time as they needed.
- Patients' feedback on both days of the inspection was exceptional, patients told us they came from afar for the expertise and local patients said, "they wouldn't go anywhere else" because staff were kind, considerate and friendly.
- The outpatient's department had introduced an outpatient specific patient satisfaction survey. The department reported a response rate in August 2018 of 5.6% and reported an overall impression of quality of care as 100%. Senior managers of the service recognised that the response rate was low and had asked staff to raise awareness of the survey with patients during clinics.
- Staff were proud to share individual examples of providing care above and beyond their daily duties. For example, we heard how clinics had been moved around to accommodate a patient's family member who had mobility issues. Staff identified other issues alongside mobility issues and placed a note on the patient's record to change the clinic room to the lower floor for the next appointment. Staff called the patient the next day to check if the patient's relative was coping and explained that changes had been made to ensure accessing the clinic was easier.
- We were provided with several examples where staff had gone the extra mile for patients. For example, a patient had travelled a distance to attend the eye clinic. The journey to the hospital took longer than anticipated. The outpatient department nurse kept the clinic open past the planned closing of the hospital. Both the nursing team and consultant stayed past their finish times to accommodate the consultation and the pre-operative assessment. A healthcare assistant went to the local supermarket and organised a food platter for the patient and their family. The patient and family were reportedly overwhelmed with the kindness of staff and how they had gone above and beyond to make the experience positive.
- Another example, was when a patient was upset and concerned about a potentially life-changing diagnosis.

The hospital made arrangement for the patient to be seen on the same day and a specialist nurse sat with her throughout, to give support and information to ensure that the visit, though it was difficult for the patient, provided the best experience.

- All consultations took place in a dedicated consultation room. Privacy was maintained with closed doors and curtains within each room to provide extra dignity and privacy where required.

Understanding and involvement of patients and those close to them

- All staff gave information sensitively and in plain language so that patients understood the information given to them. We saw that clinicians communicated information in a respectful and supportive way.
- All patients we spoke with said they felt informed about the procedure and were involved in decision making prior to being referred. Over the course of the inspection process, we observed staff interacting positively with patients and those close to them.
- We spoke with 12 patients who all reported receiving excellent communication from staff whilst at the hospital and prior to the appointment. They said the communication was exceptional, they were well informed and had no hesitations to call if they needed further assistance. This was supported by the recent patient satisfaction results which reported patients advised communication prior to their appointment was 90% excellent or good.
- The clinical nurse specialist nurse was present at appointments where the clinician delivered bad news. They supported the patient and clinician allowing them to discuss any physical or emotional concerns.
- Staff told us they responded in a compassionate and in appropriate way when patients experienced emotional distress. They gave examples of where they supported patients who had phobias of needles and patients who were frightened of the outcome of the tests.
- Staff were keen to coordinate care to meet the needs of their patient and the person accompanying them. For example, on inspection, staff changed the lighting in a consultation room to accommodate a person's photophobia.
- Patients were given the time to discuss treatment options and were encouraged to be part of the decision making. During consultations we observed doctors discuss treatment plans, preferred options and convenience of having the treatment.

Emotional support

- Staff understood the impact of personal care and the emotional and social needs of patients. The gave examples of where they provided reassurance and comfort to patients. We also observed this on inspection, staff talked to patients about their family and loved ones whilst providing care.
- The service offered a whole host of supportive therapies these provisions ranged from counselling services to Macmillan provisions to support the patient's emotional needs. Staff offered patients and their relatives literature and signposted patients to available services. Within the one-stop breast clinic service, a team of clinical nurse specialists were available to support patients with a cancer diagnosis.
- The overall patient satisfaction survey for September 2018 reported that 100% of patients reported they were given the time and attention they needed.

We observed heart warming interactions between patients and staff, we saw that patients valued the friendships they had built with staff members. We saw from conversations that patients had formed a strong bond with their consultant and the nurses.

Are outpatients services responsive?

Good

We rated responsive as **good.**

Service planning and delivery to meet the needs of local people

- Service planning and delivery was focused on person centred care. Patient's individual needs and preferences were centre to the delivery of tailored services.
- There was clear signposting within the hospital guiding patients to the outpatient's department, physiotherapy and different clinics. Signage was clear

for refreshments, toilets and baby changing facilities. Refreshments were available from vending machines and access to the hospital restaurant was close by on the ground floor.

- The service complied with the NHS England's Accessible Information Standard. This was a legal requirement for services to identify, record, flag, share and meet the information and communication needs of patients and other groups with disability, impairment or sensory loss.
- The outpatient's department (OPD) was open 7am to 10pm Monday to Saturday. Staff told us that the last patient was usually booked in at 9pm which gave staff the opportunity to tidy the clinic areas before they left. The majority of patients were seen in the clinics for orthopaedics (36.5%), cardiology (10.5%) and ears, nose and throat (7.5%).
- There was an innovative approach to providing integrated person-centred ways of care that involved other services, for those with complex needs. For example, the service had links to experts in specialist hospitals so that they could directly refer the patient to speed up the referral process.
- The service was flexible, providing informed choice and ensured continuity of care. For example, clinic times were designed to incorporate any appointments for patients needing an emergency appointment.
- Facilities and premises met the needs of a range of patients who used the service. Patient feedback was sought when planning the service, for example the waiting area had recently been redesigned following feedback from patients.
- The service environment was wheelchair friendly, patients accessed the top floors via a lift.
- The service did not see patients with severe learning disabilities or with complex needs, booking staff signposted people to other providers. Where patients with a disability was deemed safe to attend clinics at the hospital, staff ensured there were suitable arrangements in place. For example, story cards were used to help explain care, or a quieter room was offered if the environment was too noisy for them.
- Patients attending the hospital had access to free car parking. All appointment letters had maps enclosed in them. Additionally, any further information regarding the appointment was also sent out prior to the appointment.
- There were a number of allied health professional services available at the clinic including physiotherapists, dietitians, speech and language therapists and therapy radiographers.
- Consultation rooms were clearly identified and signs indicating that a room was occupied were in clear sight. Toilets were clearly marked and each had an alarm bell to call for staff.
- The waiting areas were clean and comfortable with adequate seating, televisions and magazines provided.
- The service delivered a paediatric service in outpatients, all children were seen within 15 minutes, if necessary a separate paediatric waiting area was assigned.

Meeting people's individual needs

- Patients were booked in at the reception area where reception staff carried out initial personal identity checks. Clinic staff were informed of the patient's arrival and went to greet them in the waiting area.
- Reasonable adjustments were made so that patients with disabilities that had been deemed appropriate for care at the hospital were able to access and use the service equally to those that did not have a disability. For example, all patients were free to move around the hospital, those who used a wheelchair used the lift and diabetic patients were offered food if there were waiting long periods of time.
- Those with complex needs and disabilities were signposted to other providers. Staff told us patient care was a priority and they would not offer services that did not fully meet the needs of their patients.
- There was a proactive approach to understanding the needs and preference of different groups of patients and to delivering care in a way that met these needs. For example, patients with hearing difficulties had access to a hearing loop system.

Outpatients

- All the concierge and reception desks at the Wilmslow Hospital had a short welcome message in braille. Information leaflets were available in braille.
- Translation services were available to those who did not speak English; staff were able to pre-book translation services prior to their appointment. However, the service at the time of the onsite inspection did not always identify and meet the information and communication needs of patients with a disability or if English was not their first language.
- We found there were no leaflets in any other language in any of the outpatient areas in the hospital. Senior staff informed us leaflets in other languages could be printed off from an online portal, but we highlighted that there was no information in patient waiting areas informing them of how they could request this. The hospital was keen to rectify this and subsequently have confirmed that they have placed posters in all patient areas detailing how to request information in a different language and format.
- The hospital was wheelchair friendly for patients requiring wheelchair access. There was a lift in the hospital, so that patients could move freely around the hospital. The hospital itself was at street level which meant patients could enter the building without any issues.
- Patients were given the option of a chaperone to join them in consultation. We were told that it was mandatory for some clinics such as the breast clinic to have a chaperone present. For non-mandatory chaperoned clinics, patients were asked prior to their appointment, if they required a chaperone. There were signs clearly explaining the chaperone process in the patient waiting area and the patient changing are
- The seating area across all areas of the outpatients department was clean and comfortable. Patients waiting areas had magazines and drinks machines. Magazines were current and there was a large choice.
- The children's waiting area was separated from the adult waiting area by a glass shield, this was located on the ground floor. We saw activity sheets for children to complete, alongside toys and colouring pens. There was also an electronic tablet available for children which was age appropriate.

Access and flow

- The hospital accepted patients from the local area, nationally and internationally, we saw that referrals were made in line with the hospitals patient referral criteria.
- International patients were managed and coordinated by HCA's central international patient centre. This meant that all paperwork and visa applications were effectively managed by one team. The central team then liaised with the hospital to book in patients.
- Patients accessed services and appointments in a way and at a time that suited them. Referrals into the hospital were made by the general practitioner, consultant referral or self-referral. Patients we spoke with were happy with the admission process and felt the process from start to finish was dealt with extremely well.
- The service minimised the length of time patients had to wait for an appointment by providing a six-day service that allowed patients to be seen anytime between 7am and 10pm.
- The outpatient department aimed to see all patients within 15 minutes of their appointment time. The service carried out spot check audits to check compliance of this standard. The service reported 83% of patients were seen within 15 minutes of their allocated appointment time in September 2018. This had increased to 92% in October 2018. Any delays were due to the consultant starting the clinic late due to delays outside the clinic.
- Patients were allotted 60 minutes for new patient appointments and 15 minutes to 30 minutes for follow up appointments. The reception staff knew how long appointment times needed to be for each individual consultant. If clinicians were breaking bad news, this appointment was booked for an hour with the flexibility to extend it.
- The service reported 3142 appointments between 1 September 2018 and November 2018, of these 263 (8.3%) patients did not attend.
- The hospital had a standard operating procedure in place for patients who did not attend for appointment. All patients who did not attend their appointment were contacted and the reason for their

failure to attend was established and an appointment rebooked if required. The hospital audited its "did not attend" patients and this was reviewed at the accountability meeting.

- The one stop breast clinic was a responsive service that allowed women to have their initial consultation, a mammogram and the follow appointment for the results within one day of calling into the clinic or on the same day. The service reported 100% of women received an appointment within one day and 64% were seen on the same day. If the patient had undergone a biopsy, a follow-up appointment was booked with the consultant, usually within 72 hours, once the results were back from the laboratory. A team of clinical nurse specialists were available to support patients with a cancer diagnosis.
- Patients had access to a 24-hour telephone helpline service, to support their needs following a consultation or minor treatment. Nurses who staffed the phones, gave advice to patients and relatives and could escalate concerns to the resident medical officer if necessary.

Learning from complaints and concerns

- There was a complaint management standard operating procedure that localised the corporate complaints' policy. This was available to staff via the intranet and set out responsibilities for complaints management.
- Complaints were addressed locally when possible, and formal complaints were managed by the senior management team. The hospital encouraged people who used services, those close to them or their representatives to provide feedback via "your feedback matters" so that they could improve the service they provided.
- The service reported no formal complaints regarding the outpatient's department between July 2017 and October 2018.
- Complaints, both formal and informal, were shared and discussed at the operational review meeting, senior managers told us they reviewed each complaint to ensure effective resolution for the patient.
- We saw that complaints were on the standard agenda at the monthly facility meetings, all complaints were discussed and actions were documented.
- Staff were familiar with the complaints process, they told us they were keen to resolve any concerns patients had immediately and would seek to resolve a concern informally first but where needed complaints were escalated and dealt with formally.

Are outpatients services well-led?

Outstanding ☆

We rated well-led as **outstanding.**

Leadership

- There was compassionate, inclusive and effective leadership at all levels. Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- The leadership in the outpatient's department shared an inspiring purpose and strived to deliver and motivate staff to succeed.
- There was a high level of satisfaction across all staff in the outpatient's department. Staff described their managers as approachable, caring, compassionate and inclusive.
- Staff we spoke with told us they felt appreciated and respected by senior leaders. We heard heart-warming examples whereby managers had compassionately supported staff through unhappy personal circumstances. Staff described the leadership team as visible and approachable.
- It was evident from discussions that leaders motivated staff and encouraged them to make improvements that bettered patient care. We saw examples of where staff had introduced daily check sheets locally to benefit patient safety, this was supported by the senior leadership.
- Comprehensive and successful leadership strategies were in place to sustain delivery and to develop the desired leadership culture. Leaders had a deep understanding of issues, challenges and priorities in their service, and beyond.

Outpatients

Vision and strategy

- The outpatients followed the hospital vision of 'exceptional people, exceptional care', which was underpinned by four value statements. These included recognising patients as unique individuals and treating everyone with compassion, integrity and kindness. This was displayed in all areas that we visited.
- Staff in the outpatients worked in line with the company's vision, they recognised their work was pivotal to driving operational excellence and developing a comprehensive service. They cared for patients as individuals and treated one another with loyalty and respect
- Staff had access to the strategic framework, the framework focused on the quality of clinical care so that the hospital continuously improved their service.
- There was a systematic approach to monitor, review and provide evidence of the progress against the strategy and outpatient plans. The overall hospital strategic framework was affiliated to five quality goals which had been chosen to ensure the hospital focused on making improvements across the outpatients. For example, we saw that the third goal was; lesson learned framework, this supported annual targets such as development of effective tools to share lessons learned.

Culture

- The culture across the hospital was exceptional, staff were proud of the team ethos and felt they were actively encouraged to shape the services they worked in. There was a high level of support to improve staff skills from senior managers, which was highly regarded by staff.
- Staff we spoke with were open and honest throughout our inspection about the service. They openly discussed achievements as well as risks and the actions they had put in place to mitigate them.
- Staff were very passionate about working in the hospital, they were motivated and committed to providing high quality patient care.
- The senior management team supported an open culture, to support this the regional chief nursing officer held informal coffee mornings at the hospital to give staff an opportunity to discuss any issues. This also strengthened the relationship between senior leaders and operational staff.

Governance

- See surgery for the main findings.
- There were comprehensive assurance systems in place so that performance issues could be escalated appropriately through clear structures and processes. These were regularly reviewed by the senior management team. For example, we saw minutes from the September and October 2018 facility governance meetings that showed staff had reviewed topics such as risk, policies, complaints and incidents.
- The governance structure was underpinned by a clear vision, strategy and framework. The governance infrastructure was clearly defined, ensuring risk was managed and reviewed. We saw that there were clear lines of accountability that harboured an open and honest culture within the service.
- There was a systematic programme of clinical and internal audit to monitor quality and operational processes. The results from audits were discussed at the departmental governance meeting and subsequent action plans were implemented and shared across other HCA sites. For example, in minutes from the November 2018 audit accountability meeting, senior managers sent letters to consultants to reiterate the importance of bare below elbows after reviewing the compliance rate of 85% in the infection prevention and control October 2018 audit.
- We found that all staff were proud about showcasing good practice. They all felt that the audits were catalysts for identifying areas for improvement.
- National guidance updates were discussed at the facility meeting, we saw that minutes referred to eight new National Institute for Health and Care Excellence (NICE) guidelines which were introduced in August 2018. The senior team took an action to review all eight guidelines to determine if they were applicable to the hospital.
- Operational staff received a governance message of the week, all staff were asked to read the bulletin and sign to confirm they understood it. We reviewed four

random governance messages from different weeks between August 2018 and November 2018. This included information about call bells, information governance beaches and incidents of low harm.

- The matron had regular one to one meetings with the manager to discuss specific issues within their teams. We saw a good rapport between both leaders, this was evident in the introduction of new processes that had been supported by one another.
- Complaints were managed in line with the Independent Sector Complaints Adjudication Service (ISCAS) code and were discussed weekly with members of the senior leadership team. All complaints were reviewed at the Governance Meeting and the Medical Advisory Committee to identify any themes and trends.
- We heard from senior managers that service level agreements in place for all third-party providers were reviewed regularly to check they achieved the agreed key performance indicators. At the time of inspection, we had no issues that had required escalation.

Managing risks, issues and performance

- See surgery for the main findings.
- We saw all staff in the outpatient's department demonstrate commitment to best practice performance and risk management systems and processes. The service reviewed clinic services to ensure that staff at all levels had the skills and knowledge to use those systems and processes effectively.
- There were robust arrangements for identifying, recording and managing risks. The hospital held an overarching risk register and all risks were entered on the register by the manager or the matron.
- On review, we found that each accepted risk had appropriate control measures in place. Risks were reviewed at the monthly facility governance meeting. It was evident regional senior team had an exceptional overview of risks within the clinic. For example, the hospital recognised that there were problems with the electronic system function for sending out reports. Control measures that have been put in place rely on manually checking the reports until the system is updated.
- There were monthly meetings and regular safety huddles, where key issues and risks were discussed, so that information could be shared amongst operational staff.
- Staff were familiar with the top three risks for their area and actively worked towards minimising them. For example, staff recognised the current speech recognition system used by doctors to record notes was not reliable and therefore returned to dictating notes whilst the software was being improved.
- The Medical Advisory Committee (MAC) at the hospital met frequently to discuss matters such as; risks, practising privileges, complaints and clinical training. We saw from the MAC minutes that meetings were well represented across all specialities and that clinicians were committed to achieving excellence.

Managing information

- There was demonstrated commitment at all levels to sharing data and information proactively to drive and support internal decision making as swell as system-wide working and improvement.
- Patient information was stored correctly and was only accessed by authorised staff
- All information regarding staff was kept on a centralised computer and accessed by managers. Staff development folders were kept in locked folders.
- Any paper assessments were scanned or entered on to the computer and then placed in confidential waste bins for shredding.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. Patient records and electronic reporting of test results were available at all times. Staff told us they had all the information needed to provide safe care and treatment.
- The service ensured all staff followed Caldicott principals to ensure that the confidentiality of patient information was secure and appropriately shared. This meant personable information was only shared when necessary and securely. For example, all staff had an HCA email account which was electronically encrypted to enable the sharing of secure information between healthcare professionals when necessary.

Outstanding ☆

Outpatients

Engagement

- There were consistently high levels of productive engagement with patients, staff, and local organisations to plan and manage services effectively. The views of patients, relatives and carers were gathered and acted on. Staff gave examples of changes that had been made because of patient feedback. For example, the hospital liaised with an external provider to offer their customers a gold standard service if they required services of the breast clinic.
- The service based all patient feedback scores on excellence, survey scores were between 98%-100% across all areas. Feedback from people who used the service and those who were close to them was continually positive about the way they received information, how they were treated and the cleanliness of the facilities. Patients spoke highly of the staff and gave examples of staff being kind and understanding.
- Services were developed with the full participation of those who use them, staff and external partners. The hospital took part in community events to actively engage with those who used the service. For example, they had recently offered free health checks to the public at a healthcare event. They had also provided basic life support training to GP surgeries within the local community.
- A dedicated staff board displaying information about shared learning and governance, was visible in the staff room. This was updated so that staff were up to date with performance and quality data.
- Staff attended corporate and local staff events organised by HCA. All staff enjoyed attending and found it a great way of getting to know each other.
- Employee schemes to recognise the hard work done by staff was in place, for example the department celebrated employee of the month and used the opportunity to praise a staff member and showcase achievements.

Learning, continuous improvement and innovation

- There was a fully embedded and systematic approach to improvement in the outpatient's department which makes consistent use of a recognised improvement methodology. Improvement was seen as the way to deal with performance and for the service to learn.
- Leaders and staff were continually striving to improve care and treatment patients received. They did this by participating in recognised accreditation schemes and projects with external organisations.
- Improvement methods and skills were available and used across the service, staff were empowered to lead and deliver change. For example, they standardised methodologies and tools so that patient safety was at the focus of all processes and systems. We saw that the ward manager had introduced consultant feedback forms to ascertain feedback about the service they provided to the doctors. All comments were reviewed and actions had been addressed. As a result of this, doctors reported their rooms contained all the right equipment.
- The clinic provided staff, at all levels, with the opportunity to apply for external training courses to continually improve their skills and widen the quality of service provided for patients. For example, staff attended the preoperative course in readiness for roles in areas where there were plans for expanding the service.

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Outstanding

Are diagnostic imaging services safe?

Good

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 training in areas relevant to their role, such as resuscitation, equality and diversity, fire awareness, information governance, and health and safety.
- Staff were required to sign that they had read the radiation protection policy that included details about current ionising radiation regulations 2017.
- Mandatory training was delivered using a combination of face-to-face training and e-learning.
- Compliance for training was 100% for diagnostic staff.

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.
- There were no safeguarding incidents reported to the Care Quality Commission between August 2017 and July 2018.
- Mandatory training included safeguarding training. There was 100% compliance for diagnostic staff. They completed safeguarding children level three and safeguarding adults level two training. Staff had access to the nominated safeguard lead who was trained to level four, if they wanted to escalate any concerns.
- Hospital policies included a chaperone policy, safeguarding adults and safeguarding children and policies. The legislation "working together to safeguard children" was referenced, as well as female genital mutilation and child sexual exploitation.
- A flow chart of how to escalate a concern was included in the policies. Safeguarding contact information was clearly displayed for staff including a flow chart that was displayed in the office for staff to follow.
- Staff we spoke with were aware of their roles and responsibilities in safeguarding and knew how to raise matters of concern appropriately.

Cleanliness, infection control and hygiene

- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- There was no methicillin-resistant staphylococcus aureus methicillin-sensitive staphylococcus aureus, clostridium difficile or Escherichia coli reported by the service between August 2017 and July 2018.
- Personal protective equipment was readily available and included gloves and aprons. Wall-mounted hand sanitizers, were available in all diagnostic areas. They included hand washing techniques bespoke to the hospital. We observed that patients were encouraged to use hand gels.

Good

Diagnostic imaging

- Staff we observed used sanitizing hand gels before providing patient care. All staff we observed adhered to the 'arms bare below the elbows' policy in clinical areas. Monthly audits of compliance were carried out with 99% to 100% compliance.
- Daily cleaning schedules were in place and clearly displayed. All privacy curtains included dates when last changed that were all recent. Equipment was labelled with "I am clean" stickers when completed.
- Sharps bins were present, all were dated, secure and not over filled. Monthly audits of sharps disposal were carried out with 100% compliance.
- Decontamination of ultrasound probes was carried out in line with best practice and recorded in the rooms.
- Infection control was included in mandatory training.
- Staff told us that if a patient presented with a communicable disease, the patient could be allocated at the end of the clinic list. A deep clean of the room would take place following the consultation or treatment.

Environment and equipment

- The service had suitable premises and equipment and looked after them well.
- Staff and patients accessed the main entrance of the hospital into the main waiting area. Patients were directed to other waiting areas depending on the diagnostic service being attended.
- The waiting areas we inspected, were free from clutter, well-lit and had adequate seating available. Fire exits were clearly marked and accessible. Access to clinical areas was restricted to staff with swipe card access to protect patients from entering unaccompanied.
- On the ground floor the main x-ray was situated that included fluoroscopy (fluoroscopy is an imaging technique that uses x-rays to obtain real-time moving images of the interior of an object).
- The magnetic resonance imaging suite was on the ground floor as well as one of the two ultrasound scanning rooms.
- Secure lockers were available for patients to store belongings during a scan. There were two rooms, that were also lockable changing rooms, one of which was wheelchair accessible. Call bells were available if needed.
- In addition, the one stop clinic for upper limb conditions was located next to these imaging facilities meaning consultation, examination, imaging, and any other care and treatment could be carried out on the same day and without needing to move out of the department.
- The mammography service was situated on the first floor with an additional waiting area for this service. A second ultrasound room was also on this floor, however; at the time of inspection, this machine was not being used. The quality of images for the downstairs machine was considered to be better. The service was awaiting an updated machine for upstairs.
- Maintenance arrangements were in place to ensure that specialist equipment was serviced and maintained as needed. All equipment seen included evidence of a maintenance check within the last 12 months.
- There were clear signs including no entry signs in controlled areas where radiation was administered. There were also 'pause and check' posters displayed for staff as a reminder to complete all checks including patient identification, correct date, dosages, no clinical reason not to proceed and secure management of scans. Quarterly audits were completed and showed 100% compliance.
- Emergency resuscitation equipment was available at the service on the ground floor. The contents of the trolley were secured with a tag. There were daily checks carried out for items not tagged, with a weekly check of the trolley and contents. Expiry dates were checked monthly and recorded on the checking sheets. Emergency drugs were stored in the trolley and monitored by pharmacy staff. An oxygen cylinder was securely fixed to the trolley. Trolleys included both adult and paediatric size contents.
- A sealed anaphylaxis kit was on top of the trolley. Following a discussion with the imaging manager, this

was moved to behind the reception desk where an emergency eye wash kit and first aid kit were stored. All diagnostic staff were verbally made aware of the move.

- For ultrasound and mammography services, situated on the first floor, in the event of an emergency resuscitation equipment was provided from the outpatient department close to these services.

Assessing and responding to patient risk

- Staff completed and updated risk assessments for each patient.
- We observed reception staff confirming the identity of patients on arrival to the service. Patients identity (name, date of birth and address) were checked.
- Patients completed registration forms that were checked on arrival. These were then inputted into the electronic record and the paper copy destroyed securely.
- Patients identity (name, date of birth and address) were checked before any scanning.
- Risks, for the service were identified, such as for the handling of hazardous substances safely, local rules for radiation safety and lone working. These were linked to the hospital risk assessments.
- Patients having a magnetic resonance imaging scan were required to complete a safety checklist to check for any implants, metal, a pacemaker or possibility of pregnancy for women between 12 years and 55 years. Any staff or visitors entering were also verbally questioned about safety.
- For patients booked for investigations requiring contrast or interventional radiology, allergy status was checked. Where radiation was being used, pregnancy status for women of child-bearing age was checked.
- Staff were required to wear badges to monitor exposure to radiation; these were analysed to check that staff were safe in that environment.
- There was an escalation policy in place for the hospital. Staff we spoke to knew how to escalate concerns about a deteriorating patient. There was an internal emergency number to call, with a resident medical officer present in the hospital who was trained for both adult and paediatric emergencies. The number was clearly visible on all clinical area phones. Otherwise, the service called for a paramedic NHS ambulance to transfer to the local NHS trust.
- All staff were required to undertake basic life support training as part of mandatory training requirements. This included a paediatric life support element. This was face to face training in line with provider requirements and aligned to Resus Council UK guidelines.
- Staff told us a scenario had been carried out to practise the management of a collapse in the magnetic resonance imaging area. The magnetic quench button (magnet run down) was easily accessible in case of an emergency. The equipment and furniture were clearly marked for magnetic resonance imaging compatibility.
- There were two radiation protection supervisors, at the service, to cover leave, that were supported by a radiation protection advisor as well as the radiologists.
- An adapted version of the World Health Organisation's (WHO) five steps to safer surgery checklist was in place for interventional radiology. The WHO surgical safety check listis a tool designed to improve the safety of surgical procedures by bringing together the whole operating team to perform key safety checks during vital phases of surgery care. It had been adapted for interventional radiology procedures. Monthly audits of the WHO adapted checklist records were completed with 100% compliance.

Radiography staffing

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- There were processes in place to ensure sufficient numbers of trained and support staff to provide safe care and treatment.
- The service had an imaging manager, a magnetic resonance imaging radiographer, a general radiographer, a mammographer and a receptionist. Any shortfalls were filled with regular bank staff particularly a bank mammographer.

Good

Diagnostic imaging

- The imaging manager worked clinically about 70% of the time, the remaining 30% being for their management role.
- There was a vacancy for a magnetic resonance imaging radiographer. Rotas were planned approximately six weeks ahead with ongoing monitoring to ensure safe staffing levels based on activity and speciality requirements. Managers utilised staff from across the region as needed. At the time of inspection, an off-duty magnetic resonance imaging radiographer came in to work to support colleagues at the service.
- A noticeboard, in the waiting area, displayed photos of the staff for the service.

Medical staffing

- The service included 35 consultant radiologists who were employed under practising privileges.
- They were employed, at the hospital, to report on images and also for interventional radiology procedures.

Records

- Staff kept appropriate records of patients' care for screening.
- We reviewed records for five patients. All were clear, completed and easily available to all staff providing care. They included the patients' name, date of birth, admit time, information about fees for self-paying patients, consent and confirmation results shared with GP, referring consultant and the patient.
- Any paper records were kept securely in areas restricted to access by staff only.
- The electronic imaging systems were password protected with staff having personal log-in details provided at the time of their corporate induction.
- The receptionist screen included a protective cover to prevent confidential information being accidentally shared.
- There were shared electronic systems for the reporting of images by radiologists. Reporting results were forwarded to referring doctors, via secure email within two days or via registered post if no email details. Urgent imaging could be reported within four hours. An example was given of when a GP had no email access and a report was deemed urgent. A staff member hand delivered the document to the GP to prevent further delay.
- Scans were transferred through the electronic system, direct to the radiologists for reporting, following each scan. The results were forwarded to GP's and referring consultants either by secure email or registered post.

Medicines

- The service followed best practice when administering, recording and storing medicines.
- Medicines were managed appropriately following guidance.
- There were no controlled drugs for the service. Contrast medicines were administered for single use procedures. This was securely stored when not in use. The only other medicines were the emergency medicines and intravenous fluids that were stored securely in the tagged resuscitation trolley and the sealed anaphylaxis kit.
- Any contrast medicines given were recorded on paper and then the batch numbers and dose given were scanned onto the patients' electronic record.
- A pharmacist visited daily to monitor stock levels as well as environmental temperature checks where the contrast was stored.
- Contrast administration was only carried out until 6pm to ensure that sufficient staff members were available, in the hospital, in case of an emergency.

Incidents

- The service managed patient safety incidents well. Staff recognised incidents 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.
- Staff reported incidents via an electronic system. Staff shared examples of incidents reported.
- There had been no never events in the reporting period between August 2017 and July 2018.

Good

Diagnostic imaging

- We reviewed an incident, that was investigated. This included a timeline of events and conclusions with lessons learned and a completed action plan.
- There was one Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) incident in the 12 months prior to inspection. We were shared and viewed the investigation report. It included lessons learned and shared as well as application of duty of candour.
- In the 12 months prior to inspection, there were a total of 45 incidents reported, all of which were classified as either low harm or no harm.
- Staff we spoke with understood the term duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.

Are diagnostic imaging services effective?

We do not rate effective in diagnostic imaging services.

Evidence-based care and treatment

- The service provided care and treatment based on national guidance including Ionising Radiation (Medical Exposure) Regulations (IR(ME)R).
- Policies were aligned to Ionising Radiation Regulations2017 (IRR17). The Ionising Radiation Regulations (IRR17) are regulations concerned with the protection against exposure to ionising radiation as a result of work activities. There was a requirement for any new policy or procedure to be read, reviewed and signed by each member of staff. The radiation safety policy and local rules for radiation safety were available to staff both as a paper copy or electronically.
- Pathways were in place for certain conditions such as breast, gynaecology or musculoskeletal conditions.
- An audit schedule was in place that included monthly environmental audits and an annual radiation protection advisor audit. A radiation protection audit includes an inspection by a radiation protection specialist to ensure ionising radiation is being managed safely.
- There was an external contract for the radiation protection advisor services. The most recent audit was in September 2018. An action plan developed following the publication of the report; this showed that all actions had been completed as planned.
- Any audits scoring below 100% were discussed with staff and action plans were completed if needed. Audits included observational as well as from records and data.

Nutrition

- Refreshments were available in waiting areas. Information leaflets included details of any fasting requirements as part of the preparation for the investigation.

Pain relief

- We observed staff checking the well-being and comfort of patients throughout their visit.

Patient outcomes

- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared their results with other diagnostic services available for the wider organisation.
- There was a quarterly peer reviewing of imaging 'reject analysis' system carried out to monitor the quality of imaging. Since July 2018, results had been within the expected range.
- Diagnostic reference levels were audited with a compliance of 85% to 95%.
- The arm clinic benchmarked against other neighbouring independent health services and they scored higher in November 2018 than others.
- Radiologists had a key performance indicator of two days for the reporting of images. Since July 2018, 50 images exceeded this target of which 10 images were longer than 7 days.

- There were no accreditation schemes, although there was a plan in place to start the imaging services accreditation scheme.
- The hospital had taken part in a study on hydro distension for primary frozen shoulders. Radiological guided treatment had shown significant improvements in objective and patient reported outcomes.
- The service was proposing to implement patient reported outcome measures, with a pilot planned in a therapy environment.

Competent staff

- The service made sure staff were competent for their roles.
- Staff employed were required to have a minimum of three years' experience. All permanent staff were required to attend a corporate induction followed by a local induction. The regular bank staff employed had received the local induction then shadowed staff until competencies were completed in line with permanent staff.
- Each staff member maintained a paper file that included details of competencies completed. We reviewed records for five staff and all had been completed appropriately. The competency framework included daily checks including quality, scanning techniques and radiation safety.
- Staff competencies were continually assessed through imaging quality reviews by consultant radiologist scrutiny and peer to peer reviews.
- All staff, for the service had received an appraisal in the twelve months prior to inspection. They were encouraged to develop their skills and make use of training opportunities.
- Radiologists were employed via practising privileges. Any update in documentation was requested prior to their expiry. Any non-compliance with requests meant that they were prevented from further work for the hospital until provided.

Multidisciplinary working

- Staff worked together as a team to benefit patients. Radiographers, nurses and other healthcare professionals supported each other to provide good care.
- There was effective internal multidisciplinary team working that included service staff and the wider hospital as well as other provider hospitals in the region.
- There was effective external team working. The service worked with referring consultants and GP's to provide care and treatment in a timely way for patients.

Seven-day services

- The hospital was open Monday to Friday between 8am and 8pm; the diagnostic service opened at either 9am or 10am. The service was not routinely open on Saturdays, although could be flexible to patients' needs.

Health promotion

- Appointments were usually available on the same day. The one stop clinics offered diagnosis and treatment in one visit, therefore helping prevent delays in recovery for patients.

Consent and Mental Capacity Act

- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.
- We observed staff obtaining verbal consent from patients before providing care. For children, verbal consent was obtained from the parent.
- If patients lacked capacity to make their own decisions staff made decisions about care in the best interests of patients and involved their representatives and other healthcare professionals appropriately.
- Staff we spoke with told us that unless the patient's representative had written proof of power of attorney, they could not consent for a scan to go ahead.
- Written consent was obtained before interventional radiography procedures and recorded in patient records.

Good

Diagnostic imaging

- There was an interpreter service available to help with consent for patients whose first language was not English.
- Audits of consent have been in place since July 2018 with 100% compliance for verbal and written consent.

Are diagnostic imaging services caring?

Good

We rated it as **good.**

Compassionate care

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- All staff introduced themselves and communicated well to ensure patients fully understood. Patients were encouraged to ask questions and were given time to ensure they understood what was being said to them.
- We observed staff interacting positively with patients and those close to them. Staff spoke to patients sensitively and appropriately depending on individual need.
- We observed patients undergoing diagnostic procedures and saw positive interactions, communication, care and treatment with patients including checking well-being during tests.
- Privacy curtains were used appropriately in consulting and examination rooms. Doors clearly indicated if rooms were available or occupied.
- Privacy capes were available to all mammography patients.
- A blind was available to use, in the magnetic resonance imaging scan rooms, between the examination room and control room.
- Patients were encouraged to provide feedback, about the service. Feedback forms were available in waiting areas. The most recent results, for outpatients, were displayed in the main waiting area showing that 100% of patients saying they would be extremely likely or likely to recommend the hospital. Diagnostic results were included in outpatient results. Between August 2018 and January 2019, the average patient rating, per month, of the imaging service was between 9.5 and 10 per month out of 10.
- Patients we spoke to told us that "It is a great service." "Can't believe I'm receiving treatment on the same day" and "very impressed."
- The upper limb arm clinic collected patient feedback with results between 95% and 100% for each satisfaction question.

Emotional support

- Staff provided emotional support to patients to minimise their distress.
- We observed staff providing reassurance and comfort to patients. Staff provided support as required.
- There was a chaperone policy for patients who may prefer additional support.
- The colour scheme of the waiting areas and clinical rooms were calming to provide a relaxing environment. Lighting was adjusted to help create a calm setting and experience as well as hearing protected in the magnetic resonance imaging room.
- There was no counselling service offered, although staff supported patients if they called for reassurance and gave extra time to patients if they appeared anxious.
- For patients with phobias or worries about the service, they were invited to visit the hospital prior to the appointment to try and allay any fears.

Understanding and involvement of patients and those close to them

- Staff involved patients and those close to them in decisions about their care and treatment.
- We observed staff interacting positively with patients and those close to them. Staff spoke to patients and those close to them, sensitively and appropriately, dependent on individual need.
- Staff respected patient choices and delivered their care with an individualised person – centred approach.

Good

Diagnostic imaging

- Patients and those close to them told us that they received information in a manner that they understood.

Are diagnostic imaging services responsive?

Good

We rated it as **good.**

Service delivery to meet the needs of local people

- The service planned and provided services in a way that met the needs of local people.
- Diagnostic services were mainly provided to self-pay patients, both adults and children.
- The service also had a contract with a local NHS trust, surgical services, for magnetic resonance imaging.
- A secure car park was available, at the rear of the hospital with ample spaces including for blue badge holders.
- There were waiting areas close to each diagnostic area with comfortable seating available. Free refreshments were available in each waiting area, including hot drinks machines, water coolers and biscuits.
- Current magazines and a daily newspaper were available whilst patients waited in each area.
- One area, of the main waiting room, had toys and colouring books to help occupy younger visitors to the service.
- There was also a quiet room where mothers wishing to breast feed privately could go. This room was also used as a multi-faith room for patients wishing to pray.

Meeting people's individual needs

- The service took account of patients' individual needs.
- The entrance to the service had doors that opened automatically. All areas were accessible for wheelchairs or those with reduced mobility.
- Lifts were available, for each level. The diagnostic service was situated on the ground and first floor depending on which tests were being undertaken. Evacuation chairs were available if lifts were unavailable such as emergency fire evacuation.
- Accessible toilets were available for public use in all areas.
- A hoist was available if needed, for transferring on to the examination table, that could be sourced from another area of the hospital.
- The magnetic resonance imaging scanner had a larger than standard bore, where patients lay. This meant that patients who may be claustrophobic, may feel more comfortable than a standard size bore. It was also suitable for any bariatric patient.
- Ear plugs and head phones were given to patients to wear, in the magnetic resonance scanner, due to the noise of the machine. Patients were given the option to listen to music if preferred, through the headphones.
- Hearing loops were present for patients, or those close to them, with a hearing impairment.
- An interpreter service was available for patients whose first language was not English. Posters were displayed in languages other than English.
- There were leaflets available in the waiting area for patients to take. All the concierge and reception desks at the Wilmslow Hospital had a short welcome message in braille. Information leaflets were available in braille.
- Staff gave examples of patients with learning disabilities who had attended for scans. They had been prepared before the visit and accompanied by carers for support.
- Patients identified as those living with dementia, were generally referred back to the referring consultant or GP at the booking stage in order to access NHS services.

Access and flow

Good

Diagnostic imaging

- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- A total of 8,816 patients were seen in the diagnostic service in the 12 months prior to inspection. This included 70 children aged between six and 16 years old.
- There were 427 mammography scans carried out, 2,649 ultrasound scans, 2,094 radiology scans and 3,646 magnetic resonance imaging scans carried out.
- Patients accessed the service following referral from a consultant or GP either by letter or electronically.
- Staff contacted patients and could offer appointments on the same day, if preferred. There were no waiting lists for the service.
- The service monitored waiting times, for magnetic resonance imaging, following arrival for scanning. Of the 20 appointment slots a day, there was between one and five patients per month who had waited up to a maximum of 30 minutes. This was usually due to a delay in consultant arrival or the patient arrival was late. If the delay was longer, than 30 minutes, the appointment would be rearranged. Between August 2018 and January 2019, the number of patients seen, for magnetic resonance imaging, within 15 minutes of their appointment time, was between 95% and 100%.
- In the 12 months prior to inspection, the magnetic resonance imaging scanner was out of order three times. Patients were rescheduled to the next available appointment.
- As the service booked appointments, staff we spoke with told us that it was unusual for patients not to attend for their appointments. In the 12 months prior to inspection, there were 44 patients that did not attend (1.99%).
- One stop clinics were available for breast services and an upper limb service. This meant patients referred from clinic for a diagnostic test, could have scans on the same day, if preferred. The only service that dates were restricted was for gynaecology as the radiologist was only available two days per week.

Learning from complaints and concerns

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- There had been no clinical complaints, in the 12 months prior to inspection, for the diagnostic service. There were leaflets available in waiting areas for patients to take regarding the complaints process.

Are diagnostic imaging services well-led?

Outstanding ☆

We rated it as **outstanding.**

Leadership

- The manager for the service had the right skills and abilities to run a service providing high-quality care.
- There was clearly defined and visible leadership for the service. There was an imaging manager who was supported by the regional manager for imaging diagnostics and the hospital and regional management teams.
- Radiography staff understood reporting structures and told us they were well supported by their manager.
- The imaging manager told us that they felt supported by senior managers and they were approachable and contactable.

Vision and strategy

- The hospital had a vision for what it wanted to achieve with posters displayed for staff, patients and visitors.
- There was no written strategy for the service, although the imaging manager could verbally explain what was most important was that the service was safe but also about plans for extending the service to be able to see more patients including on Saturdays.

Culture

- The manager at the service promoted a positive culture that supported and valued staff.
- There was an open and clear culture that encouraged the reporting of incidents to learn from them and improve quality for patients accessing the service.

- There was a positive attitude and culture where staff valued each other. Staff reported good team working and a sense of pride providing care using a team approach.
- All staff, we spoke with, were passionate about the service they provided.

Governance

- See surgery for the main findings.
- The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care.
- A clinical governance process was in place within the service that allowed risks to be escalated to senior management levels in the organisation.
- Hospital policies were in place as well as service specific procedures and processes including the local rules and two radiation protection supervisors. Annual radiation protection audits had taken place by the radiation protection advisor
- A quarterly report was produced by the provider that included information such as incidents, patient satisfaction, risk and audit.
- Governance meetings were held monthly with members invited from all areas of the hospital including the imaging manager for diagnostics. The standardised agendas included review of previous minutes and outstanding actions. Items discussed and reviewed included incidents, patient experience, risks, training and policy updates.
- Staff competencies were assessed through imaging quality reviews via consultant radiological scrutiny and peer to peer reviews.
- There was a central human resources department, for the organisation, who managed the recruitment processes as well as a local team. Staff files were stored electronically. Managers could view their team on the system.
- There was a local radiation protection committee who met bi-annually with agenda focussed on compliance with IR(ME)R regulations for the hospital and regionally. There was a corporate radiation protection committee with quarterly meetings. Attendees represented services from all provider locations. Radiation safety was discussed including any incidents, monitoring processes and training.
- The medical advisory committee meetings included radiologists.
- There were service level agreements in place with external private companies for services such as radiation protection advisor, waste disposal and decontamination.

Managing risks, issues and performance

- See surgery for the main findings.
- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- The service had a risk register that included risks for the service. The imaging manager could articulate the top risks for the service and these were reviewed on a weekly basis. Control measures were in place to help reduce risks identified.
- Risks were included in monthly governance meetings as a standing agenda item.

Managing information

- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems.
- Electronic systems were password protected. Information governance was included in mandatory training.
- Patient information was transferred via secure electronic systems or registered post.
- Electronic systems were backed up securely.
- Any paper records received, were scanned onto the electronic system and then destroyed safely.

Engagement

- The service engaged well with patients and staff to plan and manage appropriate services.
- Public engagement was mainly through interactions, at the centre and via the feedback from the patient feedback forms.

Good

Diagnostic imaging

- There were photos of staff displayed, on staff noticeboards, for patient and visitors to view.
- Minuted team meetings took place monthly with an organisational agenda template. Items discussed included training, pathways, national guidance, patient feedback, incidents and CAS alerts. They included information about the service and information shared from other hospital areas.
- Information from monthly governance meetings and governance messages of lessons learned were shared with staff via the imaging manager.
- Feedback, about services, was sought from referring consultants. Since November 2018, six consultants provided positive feedback with all rating the service as five out of five with comments such as “superb quality and protocols” and “staff communicate very well with doctors to ensure correct images are taken.”

Learning, continuous improvement and innovation

- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.
- Some staff worked in other organisation locations and shared best practice.
- The hospital had an arrangement with a healthcare provider to reduce the waiting times for patients accessing cancer treatment. From January 2019, the hospital had been selected as a specialist centre for breast cancer. In addition, the hospital had shared their joint video with the other partner organisation.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital found innovative approaches to provide integrated person-centred pathways of care. We saw and heard of examples where staff ensured patients received a service tailored to their needs. This ranged from arranging appointments out of hours to see consultants before work, changing the lighting in clinic rooms and changing the location of clinics to help patients living with mobility issues.
- The clinical nurse specialist team offered a unique service to patients who had been diagnosed with cancer and appointments were patient led, supported by the nurse. For example, we saw there were provisions in place such as a story book to help parents explain to their young children about the cancer diagnosis and the different stages of treatment.
- There was a bespoke hospital wide emergency response process that consisted of designated roles for clinical and non-clinical staff in the event of a clinical emergency.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should consider a written strategy for the diagnostic service.