Nuffield Health North Staffordshire Hospital

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Nuffield Health North Staffordshire Hospital is operated by Nuffield Health.

The outpatient department has 12 consulting rooms, a clinical room for minor procedures, a treatment room and a phlebotomy room. A phlebotomy room is a room used to collect blood from patients.

Diagnostic services including; X-ray, mammography, fluoroscopy and ultra sound services are completed from this location. MRI and CT services are also available within the hospital but are performed by another organisation and were therefore not inspected during this inspection.

The hospital also has 38 individual patient bedrooms each with ensuite facilities. Facilities include three operating theatres, two with ultra clean air flow systems and one general theatre.

The hospital provides services to adults and children and young people. These services include outpatient services, diagnostic and imagining services, surgery and medical care. We only inspected outpatients and diagnostics during this inspection.

We carried out an unannounced visit on 14 and 15 August 2019 and inspected outpatients and diagnostic and imaging which are two core services at this location. We did not inspect the surgery or medical care core services during this inspection. As we only inspected two core services we are not able to aggregate ratings at location level.

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.

For the purposes of this inspection, the main service provided by this hospital was outpatients. Where our findings on outpatients for example, management arrangements also apply to other services, we do not repeat the information but cross-refer to the outpatient service report.

Services we rate

As we only inspected two core services we are not able to aggregate ratings at location level. However, the two core services we inspected during this inspection were both rated as **Good** overall.

- The service had enough staff to care for patients and keep them safe. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well and followed safe infection prevention and control practices. Safety incidents were reported and investigated in an open and transparent manner and lessons were learned and shared with the wider team. Staff collected safety information and used it to improve the service. Staff had training in key skills and understood how to protect patients from abuse. Some staff were not up to date with all their training needs. However, a recovery plan was in place to address this.
- Staff provided effective care and treatment and supported people to manage their pain. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and key services were available six days a week. A proactive approach to health promotion and education was followed and staff supported people to make decisions about their care. However, staffs' understanding of the Mental Capacity Act 2015 should be improved to ensure that if people who were unable to make decisions about their care attended the hospital, they would be consistently supported in accordance with the Act.

Summary of findings

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

We found areas of outstanding practice in outpatients:

- The service used creative and innovative methods to plan care to meet the long-term health and wellbeing needs of local people. Staff worked well with other services and used a proactive approach to ensure people's individual needs were met. People could access the service in a very timely manner and waiting times from referral to treatment were consistently better than national standards. An inclusive approach was used to manage complaints and staff used complaints as an opportunity to redesign services to improve patient care.

However, we also found the following issues that the service provider needs to improve:

- The provider should explore how to evidence that all staff have understood and can apply the requirements of the Mental Capacity Act 2005.
- The provider should continue to make improvements to the outpatient and diagnostic department environments so they are dementia friendly.
- The provider should continue with the implementation of the observational audit of the Five Steps to Safer Surgery checklist to improve staffs' compliance.
- The provider should consider monitoring and recording the number of appointments patients did not attend (DNA) in diagnostics and imaging.

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

Nigel Acheson

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Outpatients	Good 	We rated this service as good overall because it was safe, caring and well-led. In addition to this, the service was very responsive and was rated as outstanding in this area. We do not rate the effective key question in outpatients.
Diagnostic imaging	Good 	We rated this service as good overall because it was safe, caring, responsive and well-led. We do not rate the effective key question in diagnostic imaging.

Summary of findings

Contents

Summary of this inspection

Background to Nuffield Health North Staffordshire Hospital

Nuffield Health North Staffordshire Hospital is operated by Nuffield Health. The hospital opened in 1978. It is a private hospital in Newcastle Under Lyme in Staffordshire and is located close to the M6. The hospital primarily serves the communities of Staffordshire. It also accepts patient referrals from outside this area.

The hospital provides the following regulated activities:

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

We have inspected the hospital four times since 2013. The last inspection took place on 3 July 2018. Surgery was the only core service inspected and the rating awarded was 'good'. The previous inspection was undertaken on 9 and 10 February 2016, and this inspection included outpatients and diagnostics combined and surgery. At that inspection, the overall rating for the provider was 'good'. We have not inspected and rated medical care as a separate core service.

Our inspection team

The team that inspected the service comprised of two CQC inspectors and two specialist advisors with expertise in outpatients and diagnostics and imaging. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

Information about Nuffield Health North Staffordshire Hospital

Nuffield Health North Staffordshire Hospital is operated by Nuffield Health. Facilities include 38 individual patient bedrooms each with en-suite facilities. The hospital has three theatres; two with ultra clean air flow systems and one general theatre.

The outpatient department has 12 consulting rooms, a clinical room for minor procedures, a treatment room and a phlebotomy room. A phlebotomy room is a room that is used to collect bloods from patients.

The hospital provides mostly surgical services but also carries out some medical care services, including chemotherapy services. The two most common procedures performed were therapeutic arthroscopies, which can also be referred to as 'keyhole surgery' and total hip replacement. The hospital does not undertake surgical procedures on children under the age of 16 years.

The hospital provides onsite x-ray, mammography, fluoroscopy and ultrasound scanning. A Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) service are also carried out on site but are managed by another provider.

The registered manager has been in post since 2010 and is also the controlled drugs accountable officer.

During the inspection, we visited the outpatient and diagnostic and imaging departments. We spoke with 17 members of staff, including; the registered manager, hospital matron, nursing staff, physiotherapy staff, radiographers, medical staff and administration staff. We spoke with 14 patients and two relatives. During our inspection, we reviewed nine sets of patient records. We also reviewed records relating to the management of the service. This included; staff records, training records and evidence of governance systems, such as; audits, action plans and patient feedback.

Summary of this inspection

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

Location activity (April 2018 to March 2019)

In the reporting period April 2018 to March 2019, hospital data showed there were there were:

- 1,634 inpatient discharges.
- 3,484 day case procedures.
- 51% of inpatient and day case activity was NHS-funded and 49% was privately funded.
- 31,634 outpatient attendances.
- 151 surgeons, anaesthetists, physicians and radiologists worked at the hospital under practising privileges.
- Two regular resident medical officers (RMO's) worked on a two-week rota.

Good

Outpatients

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

Are outpatients services safe?

Good

Outpatient services were previously inspected as part of the outpatient and diagnostic services. This is the first inspection where core services have been separated. Outpatients and Diagnostic services were previously rated as 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.**
- Staff received and kept up-to-date with their mandatory training. This training was comprehensive and met the needs of patients and staff. Mandatory training included topics such as; infection prevention and control, basic life support, safeguarding, moving and handling, health and safety and mental capacity training which supported staff to work effectively with people with additional needs such as mental health conditions, dementia and learning disabilities.
- Managers monitored mandatory training and alerted staff when they needed to update their training.
- At the time of our inspection, the overall training compliance records for this location was 90% which was within the provider's mandatory training target.
- Some mandatory training topics had high compliance rates, such as incident reporting at 95% and information governance at 97%.
- However, some topics had lower compliance rates that fell below the provider's compliance rates. This included the training topics of basic life support at 73% and moving and handling at 62%. Manager's told us some of the staff who had not completed this training were bank staff (temporary staff) who were not currently working at the service. They also told us that permanent staff who were not compliant with these training had been booked onto planned training courses. Staff we spoke with during inspection and information on staff notice boards confirmed that these training sessions had been booked. This meant that plans were in place to address training compliance gaps.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.**
- Staff received training specific for their role on how to recognise and report abuse. Three levels of children's safeguarding training were available to staff dependent on their role. In addition to this adult safeguarding training was also available. Training records showed that the average training compliance for safeguarding training overall was 97%.
- One staff member at the hospital had completed an additional higher level of safeguarding training compared to the other staff. This staff member, alongside other staff at provider level were available to provide specialist safeguarding advice to staff as and when this was required.

- Staff told us how they would identify adults and children at risk of, or suffering, significant harm and how they would work with other agencies to protect them. The information staff told us showed they understood the provider's safeguarding policies and procedures, including how to make a safeguarding referral and who to inform if they had concerns. These policies and procedures met the requirements set out by national safeguarding guidance.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**
- Our observations and review of records showed that staff followed the provider's infection prevention and control (IPC) policy.
- Staff followed infection control principles including the use of personal protective equipment (PPE) such as gloves and aprons.
- All outpatient areas were clean and had suitable furnishings which were clean and well-maintained.
- Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.
- The hospital site, which including outpatient areas scored 98.88% in the 2018 Patient-Led Assessments of the Care Environment (PLACE) audit under the cleanliness domain. This was higher than the national average which was 98.5%.
- Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.
- All patients who visited outpatients for pre-operative assessments were screened for infections and appropriate action was taken in response to positive screens to ensure patients were protected from the risks associated with these infections.
- Regular audits were completed to assess and monitor the staffs' compliance with the IPC policy. The January 2019 hand hygiene audit showed 95% compliance with the IPC hand hygiene requirements. Action was taken to address areas for improvement in response to these audits. For example, staff received feedback and/or additional training to facilitate an improvement in their IPC compliance.
- Monthly, multidisciplinary and multiagency infection prevention and control meetings were held. Minutes from these meetings showed that best practice in IPC was discussed and effective systems were in place to ensure best practice and IPC changes were shared with all staff.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**
- The design of the environment was appropriate. It was spacious and fully accessible to patients who had additional mobility needs.
- The hospital site, which including outpatient areas scored 95.59% in the 2018 Patient-Led Assessments of the Care Environment (PLACE) audit under the condition, appearance and maintenance domain. This was higher than the national average which was 94.3%.
- The service had suitable facilities to meet the needs of patients' families. There was adequate seating for patients and their families and a child friendly area with children's toys.
- The service had enough suitable equipment to help them to safely care for patients. This included equipment required to complete patient observations, such as blood pressure and temperature monitoring and weighing scales.
- Staff carried out regular safety checks of specialist equipment. This included checks of the patient observation equipment referred to above and emergency equipment such as resuscitation trolleysies.
- Emergency call bells were located around the outpatient department. Staff told us how this call bell system had recently been successfully used to raise the alarm in response to medical emergency in the department.

- Staff disposed of clinical waste safely and effective systems were in place to ensure this waste was removed from the hospital in an appropriate, safe manner.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**
- All outpatients were under the care of an appropriate consultant who had practising privileges at the hospital. Practising privileges ensured that all health and social care professionals involved with patient or client care are qualified, competent and authorised to practice.
- Staff responded promptly to any sudden deterioration in a patient's health. Staff completed patient observations, such as blood pressure readings, oxygen saturation readings and patient temperatures to assess and monitor patient's health. They also used a nationally recognised tool called the National Early Warning Score 2 (NEWS2) to identify deteriorating patients and escalated them appropriately. Staff showed us a sepsis toolkit that was located in the outpatient department. This kit contained sepsis screens, equipment required for obtaining blood cultures and the pathway to follow if sepsis was suspected.
- Staff shared key information to keep patients safe when handing over their care to others. This included urgent and routine scenarios. For example, we saw that when a patient's blood pressure was abnormal during a pre-admission assessment, the staff member contacted the patient's GP immediately to share their findings to ensure this was urgently investigated further.
- Staff used recognised tools to complete risk screens and assessments for each patient on arrival and updated them when necessary. For example, all patients who attended outpatients for pre-admission assessments were asked about their falls' history. If a patient was identified as being at risk of falling, a record of this risk was recorded and handed over to in-patient staff if the patient was due to be admitted for surgery. In-patient staff would then review this risk on admission and complete the required risk assessment and management plans.
- Staff knew about and dealt with any specific risk issues. For example, staff were able to access records that showed the risk assessments and management plans for patients who were attending outpatients post-surgery. This enabled them to check that patients were compliant with post operation risk management advice, such as the use of compression stockings to prevent blood clots. Staff reminded patients of the agreed risk management plans where required and updated risk assessments if changes to risk had been identified.
- The service had systems in place to access mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. This included urgent support and assessment by the Resident Medical Officer (RMO) who would refer to local mental health urgent care services if required. Non-urgent and routine physiological support could also be accessed within the provider's wellbeing services.

Nurse staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank staff a full induction.**
- The service had enough staff of relevant grades to keep patients safe. The service had very low vacancy rates
- Managers accurately calculated and reviewed the staffing numbers and skill mix needed for each shift and the numbers of staff on all shifts matched the planned numbers.
- The service had a very low turnover rate. The turnover rate for nursing staff between May 2018 and April 2019 was 1.2% and 0% for healthcare assistants.
- Managers limited their use of bank staff and requested staff familiar with the service. The service had very low

rates of bank staff. Records showed that between May 2018 and April 2019 only 1.7% of shifts were filled by bank staff as permanent staff covered staffing gaps where possible. of the total use of nursing bank staff was 1.7%. Managers told us that all bank staff received a full induction and completed the same training as permanent staff.

Medical staffing

- There were no medical staff employed directly by the service, with all consultants working under practising privileges. All consultants carried out procedures that they would normally carry out within their scope of practice within their substantive post in the NHS. Consultants new to the hospital received a formal induction and could work under practising privileges only for their scope of practice covered within their NHS work.
- Consultants with practising privileges were required to be contactable always when they had a medical patient at the hospital Nursing staff told us that they could call and speak with the consultants at any time for advice if a patient had contacted them with a request to bring forward an appointment, for example.
- The hospital director and medical advisory committee (MAC) had oversight of practising privileges arrangements for consultants. We saw evidence in the MAC minutes of decision-making for renewing or granting privileges.
- Two resident medical officers (RMO's) worked at the location. These were primarily used for in-patient care. However, they were also used in the event of any medical emergencies that took place in the outpatient department. For example, records showed an RMO had reviewed a patient who fainted in reception in the days leading up to our inspection.
- Between May 2018 and April 2019, records showed that 151 doctors had practicing privileges at the service. These doctors covered a variety of clinical specialities and their practicing privileges were reviewed every two years to ensure they were suitably skilled to provide safe care.
- Staff records showed that appropriate checks were made that ensured they were safe to work with patients. This included requesting and reviewing criminal history checks and references from previous employers.

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.**
- Patient notes were a combination of electronic and paper records and were comprehensive, legible and up to date. All the records we viewed contained a contemporaneous account of each patient's journey. We saw that risks such as allergies were clearly recorded as soon as this information was disclosed by the patient.
- Patient records were available for every patient who attended outpatient clinics. This included a GP referral letter.
- All records were stored securely in line with the Data Protection Act2018. All staff who needed to access records could do so as and when required. This included the physiotherapists who worked off site at a satellite location.
- When patients transferred to a new team within or outside of the hospital, there were no delays in staff accessing their records. Summaries of each patients' care were shared with GP's and in medical emergencies records were shared with staff at the local NHS acute hospital.

Medicines

- **The service used systems and processes to safely prescribe, administer, record and store medicines.**
- Staff followed safe systems and processes when safely prescribing, administering, recording and storing medicines.
- Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Good

Outpatients

- Medicines requiring cool storage were stored appropriately and records showed they were kept at the correct temperature, so would be fit for use.
- All medicines stored in cabinets and refrigerators were found to be properly stored in intact packaging and were in date.
- All outpatients were asked to share information about the medicines they were already prescribed and any known allergies. A record of this was kept and updated throughout each patient's outpatient journey.
- Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. This included access to pharmacist advice from an on site pharmacy when required.

Incidents

- **The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**
- Staff knew what incidents to report and how to report them and records showed they reported incidents appropriately and promptly, in line with the provider's incidents policy. Information shared with us prior to our inspection showed there had been 26 incidents in outpatients and diagnostic imaging between April 2018 and March 2019.
- Managers investigated incidents thoroughly and in accordance with the provider's incident policy and where necessary learning had been shared with staff to ensure the risk of future incidents occurring was minimised.
- There had been no never events within outpatients. 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. However, learning from a never event from surgery had been shared within all departments at the hospital and in other services operated by the provider. This showed learning from incidents was effectively shared with the wider team.
- Staff understood the duty of candour, Regulation 20 of the Health and Social Care Act 2008, which relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant person) of 'certain notifiable safety incidents' and provide reasonable support to that person. Incident records showed they were open and transparent and gave patients and families a full explanation if and when things went wrong. Patients and their families were involved in incident investigations where indicated.

Safety Thermometer

- **The service used monitoring results well to improve safety. Managers collected safety information and shared it with staff, patients and visitors.**
- Safety thermometer/performance data was collected and displayed in all departments. This information was collated and displayed as a whole site document rather than individual service specific data. However, this meant staff and patients could ascertain safety information for the whole site which would help them make an informed decision about where they wished to receive their overall care and treatment.
- Safety thermometer information for the hospital between January 2018 and March 2019 showed there was 100% harm free care which was better than the national average which averaged between 93 and 94% during this time.

Are outpatients services effective?

Good

We currently inspect but do not rate effective for outpatients.

Evidence-based care and treatment

Good

Outpatients

- **The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.**
- Policies were up to date and assessed to ensure they did not discriminate based on race, nationality, gender, religion or belief, sexual orientation or age. Staff in outpatients had a good awareness of and had read local policies. They could give us examples of how to find policies and when they had used them
- Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. For example, a one stop breast clinic was provided in accordance with the 2009, 'Going Further on Cancer Waits: The Symptomatic Breast Two Week Wait Standard'. This support guide devised by NHS Improvement, the NHS National Cancer Action Team and Breakthrough Breast cancer state that the gold standard for breast cancer waits is the provision of one stop clinics where patients receive medical assessment and diagnostics and biopsy (if required) within one appointment.
- Pre-admission outpatient appointments were held to ensure the National Institute for Health and Care Excellence (NICE) Routine preoperative tests for elective surgery guidance was followed. This included the completion of recommended tests prior to planned joint replacements as required, such as; blood tests and electrocardiograms (ECG's) for patents over 65 years of age. Managers checked this guidance was being followed and audits showed 100% compliance with the requirement to carry out pre-admission appointments when required.
- The service had a local audit programme that included audits of records, risk assessments and a chaperone audit. We saw that where required action plans were devised and followed to improve the effectiveness of the care and treatment within the outpatients department.
- Physiotherapists followed best practice guidance to ensure rehabilitation was effective. For example, post joint replacement rehabilitation programmes were bespoke and based on the type of prosthesis used as post-surgery precautions varied dependent on prosthesis type.

Nutrition and hydration

- **Patients attending the department could access food and drink if required.**
- Self-served water and hot drinks were available to all patients within the outpatient's department. Staff said they would support patients to use these facilities if required.
- Patients were usually only in the department for short periods of time. However, staff told us they could provide meals to patients if required via the hospitals catering facilities. This included the provision of specialist and modified diets if required to ensure patients individual needs were met.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**
- Patients were asked about their pain at each appointment and were advised appropriately in how to manage this. Staff also prescribed, administered and recorded pain relief accurately.
- A new pain management advice service had recently been developed that involved a physiotherapist and pharmacist working with patients to assess and manage pain. This had a focus on educating patients that experiencing some pain was to be expected but that movement was an effective form of pain management when used with prescribed medicines.
- Staff encouraged patients to participate in national outcome measures that included the subjective measurement of pain both before and after surgical interventions.

Patient outcomes

- **Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**
- Whilst the outpatient department did not specifically monitor patient outcomes, the staff contributed towards the data collection for the National Joint Registry and the Patient Reported Outcome Measures

(PROMs). PROMs are questionnaires patients complete on their health and quality of life. The information collected from can help to monitor patient progress, facilitate communication between professionals and patients and/or help to improve the quality of . PROMs data for the hospital between April 2017 to March 2018 showed that 86.6% of eligible patients were supported to complete PROMS questionnaires at their outpatient pre-operative appointment.

- The hospital had been accredited with the Macmillan Quality Environment Mark (MQEM). The MQEM is a detailed quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer. To achieve this accreditation, the hospital evidenced that they provided good outcomes for people in terms of; ensuring the environment was welcoming and accessible to all, showing that staff were respectful of people's privacy and dignity and supportive to patients' comfort and well-being, listening to patients and giving them choice and control over their care.

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised staff's work performance and provided support and development.**
- Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Effective recruitment systems were in place to ensure staff were suitably skilled to work in their roles.
- Managers gave all new staff a full induction tailored to their role before they started work. Staff told us this included face to face meetings with the heads of each department within the hospital. They said they found these very helpful in helping them to understand how all the departments within the hospital worked together to provide effective, joined up patient care.
- Managers supported staff to develop through yearly, constructive appraisals of their work. The staff appraisal rate at the time of our inspection was 100%.
- Staff had the opportunity to discuss training needs with their line manager and they were supported to develop their skills and knowledge. This included the completion of specialist training to help them develop areas of specialism. For example, some physiotherapists had completed additional training to enable them to provide water-based rehabilitation.
- Processes were in place to ensure staff were competent to carry out their roles. This included the formal completion of clinically based competency checks and also reviews of doctors continued professional development.
- Managers made sure staff attended team meetings or had access to full notes when they could not attend. This ensured staff were kept updated about changes in practice.
- Managers identified poor staff performance promptly and supported staff to improve. If required staff were suspended from practice whilst investigations of competencies took place.
- The hospital ensured qualified nursing staff continued to maintain their registration. Information supplied by the hospital showed 100% completion rate of validation of registration for nurses and for doctors working under practicing privileges.
- Consultants applying for practising privileges had to demonstrate their competency prior to undertaking any new procedures in the department. This was done by seeking evidence from their NHS practice.

Multidisciplinary working

- **Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**
- Staff worked across health care disciplines and with other agencies when required to care for patients. Examples of this included physiotherapy and pharmacy staff working together to meet patients' pain management needs. And staff liaising with doctors and other health and social care professionals in GP surgeries and acute NHS services to ensure that the complex and long term needs of patients were managed effectively.

- Staff coordinated and attended multidisciplinary meetings to discuss patients and agree their care and treatment options as required. Staff worked with imaging and medical staff at the local acute NHS trust to do this. improve their care.
- Patients requiring urgent suspected cancer assessment could see all the health professionals involved in their care in one -stop clinics. These one-stop clinics were available to patients with suspected breast and prostate cancers.

Seven-day services

- **Outpatient services were available six days a week to support timely patient care.**
- Medical and nursing outpatient services were available from 8:30am until 8pm Monday to Friday and 8:30am until 1pm on a Saturday.
- Physiotherapists supported outpatient services Monday to Friday only.
- Radiology staff supported outpatient services Monday to Friday and on Saturdays as required.

Health promotion

- **Staff gave patients practical support and advice to lead healthier lives.**
- Staff assessed each patient's health and provided support for any individual needs to live a healthier lifestyle. All patients were asked lifestyle questions and participated in a health assessment to identify any health promotion needs. This included calculating each patients' body mass index (BMI) and asking questions about smoking, alcohol and other substances that can be abused.
- All patients who smoked were offered the opportunity to be referred to smoking cessation services. The service had consistently scored 100% for offering this service for over a year.
- All surgical patients were given the opportunity to attend and exercise at the provider's gym and wellbeing facility that was located near to the hospital. This service focused on active rehabilitation and long-term fitness and wellbeing and consisted of physiotherapy and personal trainer consultation/ sessions. This service was offered at no extra cost to private patients and at a reduced fee to NHS patients.
- Plans were in progress to offer a weight reduction and wellbeing service to patients whose BMI was higher than the safe level for surgery. This would help prepare this patient group for safe surgery.
- The service had relevant information promoting healthy lifestyles and support in waiting areas and in consultation rooms. People were directed to this information as required.

Consent and Mental Capacity Act

- **Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. Most staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**
- Where applicable, staff gained informed consent from patients for their care and treatment in line with legislation and guidance. Patients' consent to care and treatment was clearly recorded in their care records. This included consent to participate in research and the sharing of information with relevant other people when required.
- Staff completed training on the Mental Capacity Act 2005 (MCA). The MCA sets out specific requirements that ensure when people are unable to make decisions for themselves, any decisions made about their care and treatment are made in their best interests using a multidisciplinary approach. Training records showed that 95% of eligible staff at the hospital had completed this training. However, some staff were unable to demonstrate how they would apply the MCA in practice when patients lacked the ability to make decisions about their care and treatment. Staff and managers told they rarely had contact with patients whose mental capacity may be diminished as patients who accessed the service generally had the ability to make decisions about their care and treatment. However, there is always a risk that patients' mental capacity can change at any time due to a variety of health reasons. This meant we

could not be assured that staff would consistently act in accordance with the MCA if a patient attended who temporarily or permanently lacked the ability to make decisions for themselves.

- Initial consent for surgery was completed by the consultant providing care in the outpatient's department. All patients undergoing surgery were consented by the consultant providing care during outpatient consultation.

Are outpatients services caring?

Good

Outpatient services were previously inspected as part of the outpatient and diagnostic services. This is the first inspection where core services have been separated. Outpatients and Diagnostic services were previously rated as good.

We rated caring as **good.**

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- Patients said staff treated them with compassion and with kindness.
- Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff told us they were allocated suitable appointment slots to ensure they had the time needed to provide care and treatment in a non-rushed manner.
- Staff followed policy to keep patient care and treatment confidential. Patients were seen in private areas and records that contained sensitive information were stored securely.
- Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude. For example, patients who disclosed unhealthy life choices, such as smoking and excessive use of alcohol were shown understanding and were supported and encouraged to seek the relevant support to make lifestyle changes.
- Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. For example, patients who had a carer role were asked additional questions and given specific advice about their own care needs and how this may impact on their carer roles. Staff ensured that suitable support systems were in place for patients who had carer needs before any inpatient admissions for care and treatment were arranged.
- The feedback from the Friends and Family Test was positive for the hospital. Between November 2018 and March 2019, 95% of respondents said they were happy with their care and treatment. The results of this satisfaction survey were hospital specific rather than department specific. Therefore, we were unable to identify outpatient specific patient satisfaction results.

Emotional support

- **Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs**
- Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw a nurse successfully offer reassurance to a patient who had received some concerning health results during routine observations.
- Staff supported patients who became distressed and helped them maintain their privacy and dignity. For example, patients who were visibly distressed were given time to gather their thoughts and compose themselves before leaving a consultation room and walking through any waiting areas.
- Specialist nursing staff supported patients who received bad news. This included clinical nurse specialists in oncology. These nurses had the skills needed to facilitate difficult conversations.
- Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. They showed empathy when discussing patients' limitations and frustrations.
- Patients who required ongoing psychological support were referred to their GP or the service's psychological service dependent on how their care was funded.

Good

Outpatients

Understanding and involvement of patients and those close to them

- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**
- Staff made sure patients and those close to them understood their care and treatment. Doctors and nurses gave people information about their diagnoses and treatment options and ensured time was allocated for patients and those close to them to ask questions. Questions were then answered in a suitable manner to ensure patient understanding.
- Staff talked with patients, families and carers in a way they could understand, using interpreters where necessary.
- All outpatient services offered patients a chaperone and departments clearly displayed signs in waiting areas and consulting rooms. Patients were given the opportunity to be accompanied by a friend or relative and there were chaperones available when personal care was provided. For example, female nurses or healthcare assistants were available to act as chaperones when required.

Are outpatients services responsive?

Outstanding ☆

Outpatient services were previously inspected as part of the outpatient and diagnostic services. This is the first inspection where core services have been separated. Outpatients and Diagnostic services were previously rated as good.

We rated responsive as **outstanding.**

Service delivery to meet the needs of local people

- **The service used creative and innovative methods to plan and provide care in a way that met the needs of local people and the communities served. It worked proactively with other organisations to improve the health of patients and other local people.**
- The service worked proactively with other organisations to improve the health and wellbeing of the local community. Staff from outpatients were involved in the provider's, 'Schools Wellbeing Activity Programme' (SWAP), which was designed to empower students to improve their wellbeing. This programme focused on four key themes with the aim of educating children and young people on physical activity, healthy diets, sleep hygiene and emotional wellbeing and resilience. At the time of inspection, 229 local children and young people had participated in this programme. Feedback from education professionals was very positive and all the schools that had participated in the programme had requested future visits from the SWAP staff. SWAP booking information showed that a further 300 children and young people were due to receive intervention from the SWAP team between September and November 2019.
- The service hosted regular, inclusive and free health promotion and education sessions. These were called, 'come and see our experts' sessions. These sessions focused on health promotion and education and comprised of presentations and/or one to one advice sessions (not consultations) on specific conditions such as, the menopause, breast care, heart disease and joint care. The sessions were advertised within the local community and were available for anyone to book onto. Staff told us that people were given information and advice about health management during these sessions and if surgical or treatment pathways were discussed, people were given information on how to access this treatment through the NHS and through private methods. This meant people were given the information needed to make informed decisions about how to access the care they required, even if it meant people would seek their care and treatment from another provider.
- An inclusive, holistic and localised approach was used with patients who were due to undergo planned joint replacements. Patients were invited and encouraged to attend a 'pre-habilitation' programme. Hospital data showed that between February and March 2019, 126 patients had completed this programme. The programme was offered to both private and NHS patients and focused on the holistic needs of this patient group. It had been developed in response to patient need as staff had identified that a number of patients who had received joint replacements were surprised about their pain and anxiety pre and post

operation, which may have contributed to a longer length of stay in hospital post operation. The programme consisted of a group-based education session which aimed to educate patients about their pre and post operation needs and the operation itself. Patients were also given literature that included written and pictorial explanations of pre and post operation exercises and precautions to follow post operation. Patient feedback from the programme was very positive and length of stay data showed that the average patient length of staff post operation had reduced following the implementation of the 'pre-habilitation' programme.

- Systems were in place to ensure other organisations and services were involved for patients with multiple or complex needs. This included the use of a 'pre-habilitation' questionnaire that patients completed prior to joint replacement surgery. This helped to flag up any social and environmental issues which had the potential to impact on post-operative recovery. If concerns were identified through this questionnaire, a multidisciplinary and multiagency approach was used to ensure these needs were planned for prior to surgery.
- The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. One stop clinics were available for people who had urgent concerns relating to suspected breast and prostate cancer. Patients who attended these clinics received medical assessment, diagnostics and biopsy (if required) within one appointment. This improved the diagnosis time of these cancers and also provided prompt reassurance to people whose tests came back as negative for cancer.
- Managers planned and organised services, so they met the changing needs of the local population. Evening and Saturday morning outpatient appointments were available to ensure that patients who worked or had carer responsibilities could access an appointment at a time that suited them.
- Prospective patients were supported to access the independent information needed to help them to make decisions about which doctors to request an appointment with. Staff who worked in administration and bookings told us they directed prospective patients to the Private Healthcare Information Network (PHIN) website or advised them to speak with their GP who could access a staff directory. This ensured people could make informed and unbiased choices about which doctor to consult with. The Private Healthcare Information Network (PHIN) is the independent, government-mandated source of information about private healthcare, working to empower patients to make better-informed choices of care provider.
- The facilities and premises were appropriate for the services being delivered. Waiting areas contained adequate seating and there was a designated children's area that contained toys. 12 consulting rooms were used which ensured there were enough private rooms available to support multiple clinics leading to efficient and effective productivity. Ample parking was also available within close proximity to the department.

Meeting people's individual needs

- **The service was inclusive and took a proactive approach to ensure they took account of and met patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**
- There was a proactive approach to understanding and meeting the needs and preferences of different groups of people. This included people with protected characteristics under the Equality Act, such as people with disabilities. Hospital data showed that 96% of eligible staff at the hospital had completed equality and diversity training. Administration and bookings staff asked effective questions during the referral process to ensure important information about patients' individual needs were identified and recorded. Processes were in place that ensured any relevant needs were planned for to enable patients to have positive and effective experiences when attending outpatients. For example, if communication needs such as; a hearing impairment or language need was identified, appropriate interpreters and

translators were requested, with patient consent, to be present during all outpatient appointments. This ensured all patients were enabled to become partners in their care and treatment.

- The service was accessible to all and patients with complex needs were supported to access services in an equitable manner. The process of room booking for clinics took account of patient's individual needs. For example, administration and clinical staff worked together to ensure that the needs of a patient who used a larger than average wheelchair were effectively met. A larger clinic room was used to ensure the patient, their relative and their mobility equipment could be suitability accommodated. This patient was also booked into clinic at a time that meant they accessed the clinic room immediately, rather than waiting in the waiting area.
- A person-centred approach was used to ensure patients received the support they needed to undergo agreed procedures within outpatients. This included patients who had specialist needs that related to a mental health condition or learning disability. A staff member told us how they had worked proactively and creatively to ensure the needs of a patient living with autism were met in a person-centred manner. The staff member who was responsible for completing a procedure with this patient spent time learning what the patient's interests were, so they could build up a rapport with them. Staff told us this patient was needle phobic, but due to the approach used by the staff member, the procedure was completed successfully and without patient distress.
- Information about care and treatment was presented to people in a format that supported them to promote effective recovery. In addition to written and pictorial information about post-operative recovery and rehabilitation, patients were able to access physiotherapy exercises in a video format. Patients we spoke with told them they found this helpful as it helped to reinforce the advice given at outpatient appointments when they were completing their rehabilitation programmes in their home environment. Staff also showed us how they could access some advice leaflets in other languages if this was required.
- Staff worked with other providers and services to ensure people's individual needs were met. Although the 'come and see our experts' sessions that were open to the public were not patient consultations, we were told that doctors intervened if appropriate to ensure urgent concerns were addressed. For example, a doctor had identified a concern that required urgent medical attention. With the person's consent, the doctor liaised with the person's GP and the person was immediately and successfully referred onto the NHS urgent two-week cancer pathway. This showed that people who had contact with the service during health promotion and education work were directed to appropriate patient pathways when needed.
- Physiotherapy outpatient interventions were person centred and tailored to each patient. Patients worked with physiotherapists to set rehabilitation goals that were meaningful to them. All patients were offered the opportunity to participate in the 'recovery plus' programme. This was provided to private patients as part of their care and treatment, but also offered to NHS patients at a reduced cost. It included membership at a local gym linked to the provider where patients could continue to receive ongoing rehabilitation with personal trainers and physiotherapy review.
- Dementia champions and a dementia toolkit were available to provide staff with the information needed to effectively support and meet the needs of people living with dementia. This included the recommendation that a double pre-operative assessment time slot would be required if a patient was known to be living with dementia. Staff were aware of this and told us this would be accommodated if required. However, some further improvements were needed to ensure the outpatient environmental was as dementia friendly as possible. Signs to show toilet locations could be made more dementia friendly by adding a pictorial prompt. Staff told us that people living with advanced dementia did not routinely access the service as this cohort of patient often had comorbidities that meant they required care and treatment at facilities where a higher level of post-operative care was available, such as a hospital with a high dependency or critical care unit.

Good

Outpatients

Access and flow

- **People could access the service in a way and at a time that suited them. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were better than national standards.**
- People could access services and appointments in a way and at a time that suited them. All the patients we spoke with told us told us they had arranged appointments that were organised to meet their needs rather than the needs of the hospital.
- Patients could book appointments through the centralised team or the website, and bookings administrative staff screened referrals and referred to the appropriate specialism.
- Patients could access the service in a very prompt manner. An audit of 100 patients who were referred to outpatients between April and June 2019 showed that 100% of these patients were offered an initial appointment within seven days of their referral.
- The NHS Constitution states that patients should wait no longer than 18 weeks from GP referral to treatment (RTT). All hospitals that treat NHS patients are required to submit performance data to NHS England, which then publicly report how hospitals perform against this standard. The maximum waiting time for non-urgent consultant-led treatments was 18 weeks from the day a patient's appointment is booked through the NHS e-Referral service, or when the hospital or service receives the referral letter.
- The referral to treatment data for the hospital showed that at the time of our inspection the location was performing better than the national standard set by NHS England which states that 92% of patients should commence treatment within 18 weeks of referral. Hospital data showed that 98.1% of patients commenced their treatment within 18 weeks. The registered manager told us the hospital averaged 95% against this standard throughout the year.
- During our inspection, one of the scheduled outpatient clinics was running late due to unforeseen circumstances. We saw that staff informed people of delays on arrival to the hospital or if appropriate by phone before scheduled appointments. Patients were given the option to rearrange another appointment at another suitable time if required. None of the patients we spoke with were caused any distress or inconvenience by the delay and the clinic appointments on that day promptly got back on track.
- A proactive and holistic approach to pre-operation assessments meant discharge planning began in the outpatients department before a patient had been admitted for surgery. This proactive approach ensured patients had the right support and equipment in place to support and facilitate safe discharge which meant the risk of delayed surgical discharges was reduced.
- A service level agreement (SLA) was in place that supported safe, prompt transfers to acute NHS care if a patient attended the outpatient department with post-operative urgent concerns. Staff told us and an incident report we reviewed showed that this SLA was used successful to ensure these transfers were prompt and effective.
- Staff monitored and took action to minimise missed appointments. Staff ensured that patients who did not attend appointments were contacted and appointments were rearranged.

Learning from complaints and concerns

- **It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously. They involved complainants in comprehensive investigations of their complaints and used their experiences and ideas to innovatively improve patient care. Patient representatives were involved in reviewing how complaints were managed to ensure they met the needs of the patients.**
- The service clearly displayed information about how to raise a concern in patient areas.
- Patients and their relatives knew how to complain or raise concerns. However, none of the patients and relatives we spoke with told us they had needed to raise a complaint or concern, as they were happy with their care.
- Staff understood the policy on complaints and knew how to handle them.

Good

Outpatients

- Managers comprehensively investigated complaints and identified themes and improvements. Only one informal complaint had been made in relation to the provision of outpatient services in the 12 months leading up to our inspection. Managers evidenced how they had proactively listened to and acted upon the concerns raised through this informal complaint. This included the innovative development of a new service aimed at supporting patients with weight reduction and management if they had been identified as unsuitable for immediate surgery due to their weight. This service was to be offered to private and NHS patients which meant an inclusive approach had been taken. The complainant had been invited to trial the new service and were very happy with the way their concern had been managed as this had led to a significant planned change in patient experience.
- Systems were in place to ensure any complaints were reviewed by the patient experience forum four times a year. This process ensured patient representatives reviewed the complaints process to ensure it was meeting patient need.
- Complainants were asked if they wished to be involved in the patient forum, so they could continue to share their experiences and be involved in reviewing and shaping service provision.
- Managers shared feedback from complaints with staff and learning was used to improve the service.

Are outpatients services well-led?

Good

Outpatient services were previously inspected as part of the outpatient and diagnostic services. This is the first inspection where core services have been separated. Outpatients and Diagnostic services were previously rated as good.

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

Leadership

- **Leaders had the skills and abilities to motivate and involve staff and patients in the running of the service. They understood and managed the priorities and issues the service faced and consistently worked towards sustaining and improving patient care and treatment. They were very visible and approachable in the service for patients and staff. There was a deeply embedded system of leadership development and succession planning.**
- The hospital was led by a hospital director and matron. Heads of department or leads were in place for each specialty and service. At a department level staff reported to the heads of department and in the case of physiotherapy they reported locally to the matron.
- There was compassionate, inclusive and effective leadership at all levels. Leaders at all levels demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. Staff told us that team leaders and the management team were approachable and responsive which enabled staff to confidently raise concerns and suggest ideas for improvement.
- Managers inspired and enthused staff. The management of the physiotherapy team had recently been changed and at the time of our inspection this staff group were being managed by the hospital matron. Physiotherapists told us this was a positive move as the hospital matron understood the local challenges and priorities which meant implementing changes in local practice was more effective. This staff group were very enthusiastic and positive about their inclusion and involvement in local initiatives, such as the opportunity to be involved in the Schools Wellbeing Activity Programme (SWAP) programme.
- Incident investigation and complaints records showed leaders and managers were very visible, open and honest with patients and their relatives. Being able to develop excellent rapports with patients meant some patients who had been through the investigation/ complaints process continued to be involved in service review and redesign through being encouraged to be involved in the patient forum.
- There was an effective and embedded system of leadership development and succession planning. We spoke with a nurse who was on the provider's future leaders programme. This was a 16-month programme where participants were given a day a week over this

time to participate in the programme. This staff member gave us examples of how they had applied learning from this programme in their working role. This included, completing an activity with staff to identify what their motivators were at work which enabled them to get the best out of their team.

- The junior sister role and recently been introduced at the service. Staff told us this presented them with a good development opportunity and provided career progression.

Vision and strategy

- **The service had a clear vision for what it wanted to achieve and a strategy to turn it into action. The vision, strategies and plans were inclusive and were developed with the involvement of relevant stakeholders. There was a clear focus on improving the health and wellbeing of local people. Staff understood and were enthusiastic about the vision, strategies and plans. They knew how to apply the strategies and plans and how to monitor their progress in achieving them.**
- The provider's vision and purpose was to improve the health and wellbeing of the nation. Its mission was to support, enable and encourage people to improve their health and wellbeing to help them get the most out of life.
- The strategies and plans were inclusive with a strong focus on improving the health and wellbeing of the local community by making health promotion and education accessible to all. Profits were invested in innovative and achievable programmes aimed to improve the health of local communities. This included the SWAP programme offered to children and young people and the 'meet the expert' sessions.
- Staff showed an understanding of the provider's charitable status and were enthusiastic and passionate about the inclusive focus of the vision and strategies. Staff told us they were proud that they could treat all patients in the same manner as the funding of their care and treatment did not impact on the care they provided.
- Staff were updated and educated on key strategic and operational messages through the, 'message of the quarter' communications. The message of the quarter at the time of our inspection focused on the provider's charitable status, current programme and care values.
- Strategies and plans also focused on the provision of long-term sustainable care. Effective systems were in place to monitor and respond to any changes in income and productivity to ensure the future sustainability of the service

Culture

- **Staff felt respected, supported and valued. They followed an agreed set of values that were focused on the needs of patients receiving care. The service promoted equality and diversity and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**
- Staff were proud of the organisation as a place to work and spoke very highly of the culture. This had also been recognised by staff from the local commissioners who had recently completed a quality assurance visit.
- Leaders were inspiring and focused on providing high quality care. This was evidenced through the enthusiasm and passion displayed by staff who told us about their development opportunities and the opportunities to develop or participate in new ways of working.
- Some staff described the staff and organisation as a, 'family'. They told us they were well supported and felt valued as the management team took the time to get to know people by name. We saw that long service awards were displayed in the outpatient's office which showed staff had been recognised by the provider for their long service.
- There was a strong team-working approach across the hospital. New staff met all heads of departments during their induction to ensure they understood the importance and roles if each team.

- Team away days were held to help build effective working relationships. Staff told us about taking part in a trip to an escape room. The focus of this away day was to show that teams do not perform well when they work in isolation.
- Staff were aware of the provider's values which were 'connected, aspirational, responsive and ethical'. Staff told us how they had recognised these values in a team member when they used a person-centred approach to engage with a person who lived with autism. They had therefore nominated them for a care values award in recognition of this.
- Staff at all levels are actively encouraged to speak up and raise concerns, and all policies and procedures positively support this process. Training records showed that 98% of eligible staff at the hospital had completed whistleblower training and staff we spoke with new the process they should follow if they needed to raise a concern.

Governance

- **Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**
- The board and other levels of governance in the organisation functioned effectively and interacted with each other appropriately. There were clear governance structures in place where a number of groups and committees, such as the health and safety committee, the medicines' management group and the infection prevention committee that fed into the quality and safety committee which in turn reported directly to the board.
- Board meeting minutes showed they had oversight of the service's performance against quality and safety measures. We saw that they were aware of areas that required improvement, such as compliance with some mandatory training topics and they had agreed a suitable recovery plan to address this.
- Partnerships, joint working arrangements and shared services were clearly set out through service level agreements (SLA's). Staff understood their roles and accountabilities under these SLA's.
- A suitable practicing privileges policy was in place that outlined the requirements they needed to follow and meet to maintain practicing privileges. This included annual submission of insurance and appraisal and a formal two-yearly review of their practicing privileges by the Medical Advisory Committee (MAC). We looked at a selection of consultant files and these contained evidence that this staff group were suitably skilled and competent to deliver care and treatment.
- A root cause analysis (RCA) panel met regularly to review completed post incident RCA's. This panel ensured that RCA's had been completed effectively and that shared learning had been planned and completed. The panel also fed into the quality and safety committee which ensured the board had oversight on incidents and the associated RCA's.

Managing risks, issues and performance

- **Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.**
- Leaders and teams used systems to monitor and manage performance effectively. This included safety thermometer data and compliance with agreed quality improvement goals, such as ensuring staff gave appropriate health promotion advice to patients who smoked. Feedback about performance was shared appropriately with staff to thank them for their work and/or share plans for improvement.
- Performance issues were escalated to the appropriate committees and the board through clear structures and processes. This included concerns about individual staff where records showed that concerns about individual staff members were appropriately reported, managed and investigated to protect patients from any risks associated with poor or unsafe performance
- Clinical and internal audit processes functioned well and had a positive impact on quality governance, with

clear evidence of action to resolve concerns. We saw that a number of audits were completed in outpatients by staff and the provider. This included medicines audits, records audits and provider led quality assurance visits based on the CQC five key inspection questions (safe, effective, caring, responsive and well-led).

- There was an effective and comprehensive process to identify, understand, monitor and address current and future risks. Staff knew how to identify and escalate relevant risks and issues and identified actions to reduce their impact. A risk register for the hospital was maintained that incorporated the risks for the outpatient department. This fed into an overall location risk register and which had oversight from the board.
- The hospital participated in national audits including the National Joint Registry, Patient Reported Outcome Measures (PROMS) and Patient Led Assessment of the Environment (PLACE).

Managing information

- **The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**
- There were robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. 97% of eligible staff at the hospital had completed information governance training.
- Staff could access patient information as and when required. They used paper based and electronic patient records that contained detailed patient information from a patients first outpatient appointment to their discharge. Work was in progress to introduce a new electronic health care record that would further improve communication and continuity of care.
- Perspective patients were supported to access the information needed to make decisions about their care. The location's website was easy to navigate and displayed the services offered. Perspective patients were also directed to the Private Healthcare Information Network (PHIN) website to enable them to access the information required to make informed decisions relating to which doctor to request their appointment with.
- Staff could access information such as policies and procedures in paper and electronic format. The policies we viewed were up to date and based on current evidence.
- Staff received helpful performance data on a regular basis, which supported them to adjust and improve performance as necessary. This included the sharing of quality and performance reports and improvement plans.
- The registered manager ensured that data or notifications were consistently submitted to external organisations as required. This included the reporting of significant events, such as serious injury or safety incidents to CQC as required and without delay.

Engagement

- **Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**
- The management team and other leaders consistently engaged with the staff through a variety of communication methods to ensure their views on care and treatment were obtained and they were updated about best practice and changes to policies and processes. A recent hospital 'newsflash newsletter' that we viewed informed staff of changes to emergency equipment, gave feedback to staff from safety scenario practices and also promoted a lifesaver app that they and their families and friends could downloaded from the Resuscitation Council UK to promote effective resuscitation.
- The registered manager held monthly coffee mornings where eight staff members were invited to attend to promote communication and staff engagement.

Good

Outpatients

- Patients were involved in the review and redesign of the service through the patient forum. Minutes of these forum meetings showed their involvement in quality assurance assessments. We saw members of the patient forum had recently completed a quality check of the outpatient department. Feedback from this quality check was then used to improve patient experience. For example, patient forum members had recommended that baskets should be placed in consultation rooms to hold patient clothing in. These baskets had been put in place following the receipt of this feedback which meant patients had a clean container to store their clothes in whilst they received care and treatment in the department.
- Staff also worked with and involved commissioners where appropriate to advocate for patients and support them to receive the care and treatment they required.
- The service worked with local GP's to identify and meet their professional development needs. Regular GP events were held to educate GP's in a variety of specialist medical topics with 22 local GP's attending the service's recent June GP engagement event.

Learning, continuous improvement and innovation

- **All staff were committed to continually learn and improve services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.**
- Staff were supported to access specialist training to develop their skills and improve patient care. This included training in; leadership, tissue viability and wound care.
- Staff were empowered to find creative and innovative solutions to improve patient care. For example, a physiotherapist and pharmacist has introduced a local multidisciplinary pain management service in response to patients who presented with complex needs or the need to be educated within this area to facilitate good recovery. A new service aimed at supporting people to achieve a healthy pre-operative weight was also being introduced to improve patient care.
- The findings of a local surgical never event had been shared with outpatient staff to ensure lessons learned were shared. Staff we spoke with were aware of the never event and told us the learning shared had highlighted the need to ensure they did not become complacent when working in the roles that they knew so well.

Good

Diagnostic imaging

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

Are diagnostic imaging services safe?

Good

Diagnostics has not previously been inspected as a separate service. We rated safe as **good.**

Mandatory training

- **The service provided mandatory training in key skills to all permanent staff and made sure everyone completed it. Appropriate systems were in place to ensure bank (temporary) staff had required mandatory training.**
- Staff received and kept up-to-date with their mandatory training. This training was comprehensive and met the needs of patients and staff. Mandatory training included topics such as; infection prevention and control, basic life support, safeguarding, moving and handling, health and safety and mental capacity training which supported staff to work effectively with people with additional needs such as mental health conditions, dementia and learning disabilities.
- Most mandatory training was available electronically with staff also receiving annual face to face training. The face to face training included basis life support, fire, moving and handling and infection prevention. Staff were assigned to mandatory training modules appropriate to their role. All staff were required to complete key modules such as fire safety, information governance, dementia, consent and life support.
- Managers monitored mandatory training and alerted staff when they needed to update their training. The diagnostics manager and matron received monthly updates of staff compliance with mandatory training within the department.
- Staff told us they received an email which detailed when they needed to update identified training.
- At the time of our inspection, the overall training compliance records for this hospital was 90% which was within the provider's mandatory training target.
- Some mandatory training topics had high compliance rates, such as; incident reporting at 95% and information governance at 97%. However, some topics had lower compliance rates that fell below the provider's compliance rates. This included the training topics of basic life support at 73% and moving and handling at 62%.
- The diagnostics manager told us 100% of permanent staff were fully compliant with all mandatory training. However, bank staff (temporary staff) who were not currently working at the service were not 100% compliant. The diagnostics manager told us bank staff had been informed they would not be able to work at Nuffield North Staffordshire if they were not able to evidence they had received all required mandatory training by the end of August 2019. This meant that plans were in place to address training compliance gaps.
- The matron told us all clinical staff had received training in sepsis and this was included within the annual basic life support training.

- The diagnostics manager was the dementia lead for the hospital. All staff had received both on line and face to face training in awareness of dementia. Dementia training was identified as mandatory training. We were told a member of outpatient's staff was the learning disabilities and training in autism and learning disabilities was also available for all staff.

Safeguarding

- **Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse, and they knew how to apply it.**
- Staff received training specific for their role on how to recognise and report abuse. Three levels of safeguarding training were available to staff dependent on their role. Training records showed that the average training compliance for safeguarding training overall was 97%.
- The diagnostics manager told us radiographers received level 3 children's safeguarding training. which included child sexual exploitation training. This was in line with the safeguarding children and young people intercollegiate document (2019). Other staff such as the radiology department assistant who did not have unsupervised access to children had completed level 2 safeguarding children training.
- Staff said they had received online safeguarding training and confirmed it included types of abuse including female genital mutilation, children sexual exploitation, domestic violence and PREVENT.
- Staff we spoke with said they had not had to report any safeguarding concerns. However, they knew who the safeguarding leads were and who to contact for advice should they have any safeguarding concerns.
- Information about safeguarding was displayed on the noticeboard in the diagnostics managers office to assist staff access timely advice and support from the safeguarding lead.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**
- The diagnostics department was visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated all areas were cleaned regularly.
- All consulting and imaging rooms we inspected had hand-washing facilities, antibacterial hand gel, paper towels, and cleaning wipes available. We saw posters displaying the World Health Organisation's 'five moments for hand hygiene.' Staff were observed washing their hands before and after each patient's appointment and patients confirmed that they observed this.
- Radiographers cleaned scanning equipment after each use with sanitising wipes. Paper covers were used on the scanning couch. They were disposed and replaced after each patient.
- Regular audits were completed to assess and monitor the staffs' compliance with the infection prevention and control IPC policy. The January 2019 hand hygiene audit showed 95% compliance with the IPC hand hygiene requirements. Action was taken to address areas for improvement in response to the audit. For example, staff received feedback and/or additional training to facilitate an improvement in their IPC compliance.
- Staff followed infection control principles including the use of personal protective equipment (PPE). We saw hand gels were available across the department and available for staff and visitors. Personal protective equipment was available and used as necessary. Staff had arms bare below the elbow when within the clinical area which is best practice to assist effective hand hygiene and infection prevention.
- Staff were observed washing their hands and using hand sanitisers in accordance with the National Institute for Health and Care Excellence (NICE) guidance (QS61 statement three).
- All staff received annual infection prevention training which included use of a light box to test the effectiveness of hand washing.
- Monthly, multidisciplinary infection prevention and control meetings were held. Minutes from these

meetings showed that best practice in IPC was discussed and effective systems were in place to ensure best practice and IPC changes were shared with all staff.

- Clinical waste was sorted and disposed of in appropriate, foot-operated waste bins. Sharps disposal bins were labelled correctly and not overfilled and did not appear to contain inappropriate waste.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.**
- The diagnostics service was located on the ground floor of the hospital adjacent to outpatients and close to the main reception. The location of diagnostics departments made it easy for patients to go between outpatients and diagnostics or direct to the diagnostics department if x-rays or other diagnostic tests were requested.
- The service had one x-ray room, a mammography room, a fluoroscopy room and separate sex changing facilities. Staff and managers told us one of the fluoroscopy room required updating and a business case for redevelopment of this room had been identified.
- The department had a range of equipment which included one x-ray machine, ultrasound machine, mammogram and a fluoroscopy machine. In addition, there were two mobile x-ray machines.
- There was a radiation protection policy which was regularly reviewed and the radiation protection officer carried out audits that demonstrated compliance with the Ionising Radiation Regulations 2017 (IRR 17).
- The service had a maintenance contract in place to attend to any faults identified in the running of the equipment, staff reported there was prompt response to any defect identified in the equipment.
- We saw some service records for the diagnostics equipment during the inspection. The hospital director told us the contracts for the diagnostics equipment were managed centrally. They told us a specialist engineer visited the hospital weekly to undertake required checks, calibration and servicing as part of the contract for the equipment, maintenance whenever possible was undertaken on site. Information confirming the appropriate servicing, calibration and maintenance of diagnostic equipment was forwarded after the inspection.
- Staff carried out daily safety checks of specialist equipment. The necessary tests had been conducted on equipment to ensure it was safe for use before it had been used in the department.
- Risk assessments were completed for all new or modified use of radiation. We saw that this considered the risks for both staff and patients in the environment.
- Rooms where ionising radiation exposures occurred were clearly signposted. There were signs and warning lights outside controlled areas where radiation was used to make it clear when it was safe to enter.
- Staff wore lead aprons to protect themselves from the risk of radiation exposure. The aprons were tested annually to ensure their effectiveness.
- Staff radiation exposure was monitored by the radiation protection supervisor and records of dose badges were recorded. All staff wore radiation exposure devices to ensure they were not over exposed. Appropriate action would be taken if overexposure was identified.
- The service used a picture archiving and communication System (PACS) to store patient images. This consisted of local and off-site servers for clinicians to securely access and view images. The IT network was monitored 24 hours per day, seven days a week and engineers were alerted if a failure occurred.
- Adult and paediatric resuscitation equipment was available and located within the department. We saw records of daily checks completed and all equipment was within expiry dates and stored securely.
- The hospital had appropriate arrangements in place for managing and disposal of waste and staff disposed of clinical waste safely.
- The service stored hazardous substances appropriately and in accordance with the Control of Substances Hazardous to Health Regulations 2002

(COSHH). COSHH is the law that requires employers to control substances that are hazardous to health. We saw up to date COSHH risk assessments to support staff's exposure to hazardous substances.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**
- There were emergency bells throughout the department which could be activated to alert staff both within the department and the rest of the hospital to an emergency. The emergency bell would also alert the resident medical officer (RMO), who had advanced life support trained training and was available 24 hours per day.
- Emergency resuscitation equipment for treating both adults and children was available within the department. Records were available to confirm the equipment was checked appropriately.
- We saw policies in place to support staff in their role in responding to patient risk. For example; the head of department had up to date files in line with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R 17) procedures, as well as standard operating procedures as required under the regulations.
- The service had access to support from a radiation protection advisor (RPA) and had two radiation protection supervisors (RPS). The RPSs worked within the department and led on specific areas and provided guidance and support to staff.
- The department had written and displayed local rules, as required by the Health and Safety Executive, in all areas where medical radiation was used.
- An annual radiation protection audit had been conducted. We saw compliance was good in the most recent audit in February 2019.
- There was information included a section on the x-ray/ diagnostic request form to confirm female patients were not pregnant. We saw radiographers had checked women were not pregnant and recorded the date of their last monthly period to rule out any risk of pregnancy. We saw there were signs displayed in the changing rooms informing patients of the importance of discussing with staff any possibility of pregnancy.
- Patients were risk assessed to ensure they were suitable to receive contrast prior to procedures. This was in line with the Royal College of Radiologists standards for intravascular contrast agent administration. A screening process where patients were asked about pre-existing clinical conditions that could impact on kidney function took place prior to procedures.
- Systems to promote security and safety were in place and well managed. There were alarm systems for secure access areas and key coded locked doors. There were fire alarm procedures and extinguishers were available and well maintained.
- There was an on-call rota for urgent out of hours radiography.
- At the time of the inspection there were no delays with reporting times. Staff we spoke with were clear of the process to follow in the event of unexpected or significant findings at the examination and upon reporting. Referrers were contacted directly by telephone, via email or letter and so sharing of results was done in a timely manner.
- We observed the processes to ensure the correct patient received the right diagnostic test at the right time. Staff completed checks in line with the requirements of IR(ME)R to safeguard patients against incorrect investigations.
- Radiology staff completed a World Health Organisation (WHO) Five Steps to Safer Surgery checklist for all interventional radiology procedures. A monthly audit of the records of the checklist was undertaken. We saw any deficiencies in the checklist had been shared with staff for example completion of allergies. We were told the audits were undertaken reviewing patient records retrospectively.
- The hospital had adopted and implemented the National Safety Standards for Invasive Procedures

(NatSSIPs). A NatSSIP supports the hospital to provide safer care and reduce the number of patient safety incidents related to invasive procedures in which surgical never events can occur.

- We observed one radiology interventional procedure. We found not all the elements of the Five Steps to Safer Surgery checklist were checked for example, the names of all staff present and the 'sign out' at the end of the procedure was not undertaken. In addition, at the checkout the names of staff present was not recorded. The matron told us Nuffield had identified a need to commence observational audits of the checklist and these were being commenced. Information we received immediately following the inspection confirmed changes had been made to undertake observational audits of the Five Steps to Safer surgery checklists.
- Staff checked that patients who required a contrast media were not allergic prior to administration. Contrast media is used to increase the differences of structures or fluid within the body and was administered by the radiologist responsible for the patient.
- Sepsis information including protocols and up to date guidance was available within the service.

Staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers reviewed and adjusted staffing levels and skill mix.**
- Staff comprised of seven radiographers and a radiology department assistant. There was one whole time equivalent (WTE) diagnostics manager, with the remainder of the staff working part-time hours between 16 and 30 hours. In addition, there was one bank radiographer who worked one day a week.
- The diagnostics manager planned rotas adjusting the staff numbers and skill mix around the requirements of patients attending.
- The hospital had an electronic rostering management system that enabled managers to effectively manage rotas, staffing requirements, skill mix and senior cover. The imaging service ensured they had appropriately trained imaging staff to maintain patient safety.
- The service monitored the staffing levels daily and weekly to ensure there were safe staffing levels to meet the number of patients seen and to ensure the service manged their individual needs.
- The manager told us they worked flexibly and covered annual leave and staff sickness and unexpected radiology requests (such as presence in theatre) within the team.
- The service did not use agency staff.
- There were no staff vacancies.
- Staff turnover was low with most staff having worked for the service for several years.

Medical staffing

- **The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment**.
- There were no radiologists employed directly by the service, with all radiologists working under practising privileges. All radiologists carried out procedures that they would normally carry out within their scope of practice within their substantive post in the NHS. Radiologists new to the hospital received a formal induction and could work under practising privileges only for their scope of practice covered within their NHS work.
- All consultants were requested to provide documented evidence of an annual appraisal so that it could be used as part of their revalidation process.
- The service had 11 radiologists who were employed by other organisations (usually local NHS trusts) in substantive posts with practising privileges with The Nuffield North Staffordshire Hospital.

Good

Diagnostic imaging

- Staff in the department told us they had good working relationships with the radiologists. They told us the radiologists were specialists in identified areas and were approachable and always gave advice and support.

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.**
- We saw patients' records were detailed and contained information about the patient, tests required and their medical history. The person who had requested the diagnostic test was identified.
- We saw medical records were stored securely within the imaging department in a locked room. Information provided by the hospital confirmed records were tracked and moved securely between departments of the hospital.
- All staff had completed mandatory on-line training, which includes information governance and the consequences of any breach in line with national legislation.
- The service provided electronically encrypted reports within a picture archiving and communication system. This was medical imaging technology which provided storage and convenient, secure access to images. This system enabled patient information to be shared across teams and services requiring the information in line with NICE QS15 Statement 12.
- All computers observed were locked and password protected when not in use. Computers were in rooms out of public areas which reduced the risk of confidential patient information being seen by other patients or visitors.

Medicines

- **The service used systems and processes to safely prescribe, administer, record and store medicines.**
- The hospital had an on-site pharmacy; pharmacists visited the department weekly to check medicines, their availability, storage and re-stock medicines when required.
- Staff stored and managed medicines and prescribing documents in line with the provider's policy. All medicines were kept in locked cabinets in the radiology department. We checked medicines and found they were all within expiry dates.
- The room temperature where medicines were stored were checked and recorded daily. Review of temperature checks showed these within the recommended ranges.
- Staff followed current national practice to check patients had the correct medicines. We observed staff ensured the right patient received the right medicine. Patient identity and dose was checked and, confirmed prior to administering.
- The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.
- The imaging department used a small number of medicines for investigations. These were largely contrast media. We saw these were stored in locked cupboards within the diagnostic imaging service.

Incidents

- **The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**
- The matron and diagnostics manager had oversight of all incidents reported within the department. An electronic system was used to manage incident reporting. From April 2018 to March 2019 there had been 26 incidents reported in the outpatients and diagnostic imaging service.

Good

Diagnostic imaging

- All staff we spoke with knew how to report incidents using the hospital electronic reporting system.
- Staff we spoke with confirmed they had reported incidents such as the quality of x-ray information and images received from a local hospital. They told us they received feedback following their reports of these incidents.
- From April 2018 to March 2019, the diagnostic imaging service had not reported any incidents classified as never events. Never events are serious patient safety incidents which 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 to have happened for an incident to be a never event.
- In the twelve months prior to the inspection, there had been no ionising radiation incidents reported at the hospital. Staff had reported incidents about poor information received from a local NHS trust.
- The service received external safety alerts appropriately and sought advice from external bodies when required as a response to incidents that occurred in the department.
- Incidents and themes were discussed in the diagnostic imaging department monthly staff meetings. These included incidents raised within Nuffield hospitals and nationally when relevant.
- We saw minutes from the Medical Advisory Committee (MAC) where incidents were discussed, and actions identified.
- From November 2014, hospitals were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 the person.
- We saw information informing staff about Duty of Candour was displayed on the staff noticeboard within the office.
- Staff told us they would inform the patient of any errors and would apologise and provide open and honest information. Information we looked at during the inspected confirmed this.We reviewed examples of incidents and saw that appropriate investigations were conducted and when appropriate lessons learnt were shared across the whole team.

Are diagnostic imaging services effective?

Good

We currently do not rate effective for this core service.

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.**
- Staff followed up-to-date Nuffield Health policies to plan and deliver high quality care according to best practice and national guidance. We reviewed the standard operating procedures (SOPs) in place across the department and saw they were clear and up to date. We saw the SOPs were based on national guidance and regularly reviewed.
- The service worked to the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R 2017 (IRR17) and guidelines from the National Institute of Care Excellence (NICE), the Royal College of Radiologists (RCR) and other national bodies.
- The service used national diagnostic reference levels (DRLs) for each piece of scanning equipment that produced radiation. DRLs are used as a guide to help promote improvements in radiation protection practice. They can help to identify issues relating to equipment or practice by highlighting unusually high radiation doses.
- Dose reference levels were set by an external radiation protection service in line with the national reference levels. Patient doses were monitored and audited. We saw results of annual audits conducted by the radiation protection advisor this audit identified no concerns about radiation levels. The diagnostics

manager told us the positive finding were due to the new digital diagnostics equipment available within the hospital, radiation rates were significantly lower than the national average.

- The diagnostics manger told us they used national recommendations for DRLs for x-rays for children.
- The hospital had processes in place to ensure that they did not discriminate on the grounds of protected characteristics. The hospital had an up to date equality and diversity policy. Equality and diversity training were part of the mandatory training programme.
- There were two radiation protection supervisors (RPS) appointed in line with Ionising Radiations Regulations. The RPSs ensured staff followed standard operating procedures and guidance. They were accessible to staff for advice and support with radiation protection procedures.
- We saw staff practice and records of images were audited against best practice and national guidelines such as mammograms, completion of x-ray films and x-ray markers.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' needs.**
- Patients received information to advise about timescales for when they could eat and drink in advance. This was provided at the time of booking, in the appointment letter and recently this information was also provided by text message.
- Water and hot drinks were available in the waiting room for patients and those attending with them.
- Staff told us if a patient had a condition that affected their need for regular dietary intake, such as diabetes or frailty, they would be prioritised to avoid disruption to their usual routine.

Pain relief

- **The service managed patients' pain effectively.**
- We observed staff asking patients if they were comfortable during their procedure for example; ultrasound scans.
- If patients required pain relief while in the departments it was prescribed by the radiologist or resident medical officer (RMO) and administered by a radiographer. Staff told us that the need for pain relief in the departments was very rare.

Patient outcomes

- **Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**
- The service had undertaken several theatre and general 'marker' audits to identify the position required for x-ray. The initial marker audit between January and March 2017 identified poor compliance with results of 24% for theatre markers and 43% for general markers. The results were shared with staff and subsequent audits from April to August 2017 have demonstrated improvement to 88% for theatre markers and 65% for general markers, further audits have been identified to ensure improvement continues.
- Radiographers working in the department participated in peer review of findings for x-rays and mammograms every three months. If there were reports of discrepancies or if the required standard was not met staff were informed and when needed additional training and support provided. The most recent audit identified 100% of mammograms were of a good standard or perfect standard.
- A review of all x-rays which had been 'rejected' was undertaken every two months. Staff were informed of the outcome of these audits and if required were provided with additional support.
- Audits had been undertaken every six months to identify compliance with reporting of x-rays by consultants who were not radiologists. The audits had identified poor compliance and had been reported at the medical advisory committee. We saw some improvement had been made although a senior radiologist told us further improvement was required.

We were told should non-reporting continue to be occur identified consultants would no longer be able to self-report x-rays. A further audit was being undertaken.

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**
- Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. There were records of radiographer's Health and Care Professional Council registration in line with the Society of Radiographers' recommendations.
- All staff were appropriately trained and signed off as competent to administer radiation which met with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R).
- The diagnostics manager told us new staff received induction, the length and content depended on their previous experience. The diagnostics manager said new staff worked supernumerary and were supervised until they were assessed as competent and confident using identified equipment and specialist procedures.
- Radiographers in the department completed competency assessments prior to using equipment. We saw records of staff training and competencies which were up to date and clearly documented. The manager of the service reviewed competencies during the annual appraisals and identified any further training needs.
- The service had recently started to have radiology students. The students were supported and mentored by the senior team members.
- The service did not have a clinical educator. The diagnostics manager told us they worked closely with the clinical educator at the local trust to support both radiology students and Nuffield radiology staff learning and development.
- There was information on the intranet and printed copies displayed for staff to access that covered up to date information about the local and national guidance.
- Managers supported staff to develop through yearly, constructive appraisals of their work. Data provided showed, at the time of the inspection, 100% of staff were up to date with their appraisal. Staff we spoke with said they found the appraisal process to be of value and development opportunities were identified through it.
- All radiologists working in the department had practising privileges which gave them the authority to work at the hospital. Appraisal information was shared by their main employer (usually a local NHS trust).This included their most recent appraisal, information with regards to training and competencies and their area of work and area of expertise.

Multidisciplinary working

- **Doctors, radiographers and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**
- There was effective team working between diagnostics staff and other staff groups within the hospital. We saw staff prioritised the patient experience and communicated well to meet their needs.
- Information was shared between radiologists and referring consultants in a direct and timely manner.
- We spoke with another speciality consultant who told us radiology staff were excellent and ensured results and/or any concerns were shared in a timely way. This ensured patients received timely treatment to meet their needs.
- Radiologists were accessible and there was a good working relationship with staff across the hospital. Staff told us they could contact them for support and guidance.
- The imaging and outpatient departments offered one-stop breast clinics where women saw the consultant had their mammogram and follow up on the same day (including biopsies if required).
- The diagnostics department had good links with the local NHS trust to provide staff with additional training and development opportunities.

Seven-day services

Good

Diagnostic imaging

- **Key services were available to support timely patient care.**
- The department was open 8:30am - 9pm Monday to Friday and 8:30 am-1pm on Saturdays.
- Radiographers covered an out of hours on call rota for urgent night and weekend services.
- There was no formal on call rota for radiologists. A senior radiologist said if urgent diagnostic scans were required out of hours patients would be transferred to the local NHS hospital.

Health promotion

- **Staff gave patients practical support and advice to lead healthier lives.**
- The service had relevant information promoting healthy lifestyles and support. There was a range of information displayed in the waiting area on health and health promotion. There were some leaflets available to advise patients about health issues including breast care.

Consent and Mental Capacity Act

- **Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. Most staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**
- Patients were provided with relevant information including the benefits and risks of procedures at the initial consultation. Patients re-confirmed their consent to procedures on the day of the procedure.
- Clinical staff completed mandatory training on the Mental Capacity Act and Deprivation of Liberty online annually. All diagnostics staff had completed this training.
- Information about the Mental Capacity Act and Deprivation of Liberty safeguards were displayed on the notice board in the office
- We asked staff about mental capacity. We found staff were unclear although they said they knew about it in principle and would know where to go should they require any information.
- Staff were aware of the process to follow if they had concerns about a patient's mental health or capacity to consent verbally to investigations. Staff told us if this was the case they would discuss with the imaging manager and the patients GP when appropriate.
- Children under the age of 16 who attended for x-rays were accompanied by a parent or responsible adult who gave consent for the treatment. Staff told us the child's capacity to understand and give their consent was important. Children needed to understand and comply with instructions to ensure their safety during the x-ray.

Are diagnostic imaging services caring?

Good

This is the first rated inspection of this service. We rated it as **good.**

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- All patients we spoke with reported that they had been treated with kindness, dignity and respect by staff.
- Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw staff treat patients in a respectful and caring manner. Staff spoke about the personal, cultural, social and religious needs of patients in a non-judgmental way. We saw staff introduce themselves and explain their role.
- All the patients we spoke with told us they had felt the staff were attentive and took the time to treat them with a caring manner.
- We spoke with two patients who told us they had been very impressed by the support and information given by the customer care team.
- The reception desk was situated away from the waiting area and so allowed for patients to speak to the receptionist without being overheard.

Emotional support

Good

Diagnostic imaging

- **Staff provided emotional support to patients, families and carers to minimise their distress.**
- Staff gave patients and those close to them help, emotional support and advice when they needed it.
- Staff supported patients through procedures by keeping them well informed throughout and provided reassurance.
- Staff told us they informed patients of any waiting times to reassure and minimise distress. Patients told us they had not experienced a long wait.
- The feedback from the Friends and Family Test was positive for the hospital. Between November 2018 and March 2019, 95% of respondents said they were happy with their care and treatment. The results of this satisfaction survey were hospital specific rather than department specific. Therefore, we were unable to identify diagnostics and imaging specific patient satisfaction results.

Understanding and involvement of patients and those close to them

- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**
- Staff made sure patients and those close to them understood their care and treatment. We saw that information was provided in a way patient understood. Patients told us they knew the reason for their x-ray or diagnostic test, including when applicable any risks involved, and this was explained to them.
- The length of appointments allowed time for staff to go through information, provide reassurance and allow flexibility to meet the needs of patients.
- Relatives or carers were permitted to remain with the patient throughout the appointment when appropriate and safe, if requested.

Are diagnostic imaging services responsive?

Good

This is the first time we have rated this service. We rated responsive as **good.**

Service delivery to meet the needs of local people

- **The service planned and provided care in a way that met the needs of local people it served.**
- There were a range of diagnostic services available to support patients who required treatment and were both NHS and self-funding patients.
- Patients attending the hospital's imaging services were a mix of privately funded and NHS funded patients (these patients had chosen the hospital as a location for their appointment through the NHS e-referral service). This meant that there were several patients who attended the service for an investigation without a private consultation.
- Radiology and scanning services were clearly signposted and staff directed patients to the relevant areas.
- The department planned services around the needs of patients with appointments available Monday to Saturday including evenings.
- The hospital and department were clearly signposted and there was ample car parking close to the department. The facilities and premises were appropriate for the services being delivered.
- The waiting areas were suitable and comfortable for adults. There was enough seating, toilet facilities and drinks available. However, there was no separate waiting room for children.
- Information was provided to patients prior to their appointments. Information included relevant information about the procedure, any fasting or samples required and directions. The information was only available in standard format and not in any other language, large print or any other format.

- Noticeboards in waiting areas were up to date and had a range of information about the processes conducted in the department and reassuring advice.

Meeting people's individual needs

- **The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**
- Wheelchair access was available at the main entrance of the department with automated doors. All areas across the department were large enough to accommodate wheelchairs and patients with mobility issues.
- The service could arrange appointments to suit the specific needs of patients, for example taking into consideration their work commitments, childcare responsibilities or travel constraints.
- Patient x-rays and other diagnostic test results undertaken at the local NHS were available electronically to provide radiologists and radiographers with information about previous diagnostic tests.
- Interpreter services were available, and staff knew how to contact them.
- Hot and cold drinks were freely accessible in the waiting areas.
- Single sex toilets were located within department.
- There were changing rooms, with lockable facilities for patients' personal possessions in the department. Larger changing facilities were also available for patients with mobility difficulties.
- Mobile x-ray services were available. These could be provided 24 hours a day with radiographers supporting an on-call rota. This meant patients who were in theatre or were restricted to bed could still have x-rays at any time of day or night.
- The diagnostics manager was the dementia lead for the hospital and had provided face to face staff training about dementia. A dementia toolkit was available to provide staff with information to effectively support and meet the needs of people living with dementia.

Access and flow

- **People could access the service in a way and at a time that suited them. They received the diagnostic tests promptly to ensure timely ongoing care.**
- The diagnostics service operated from 8.30 am to 9pm Monday to Friday and 8.30am to 1pm on a Saturday.
- Referrals for x-rays were taken from the patient's doctor or a consultant. Patients could self-refer for mammograms or testicular ultrasound.
- A customer care team managed patients' appointments. Staff told us most patients were seen within one week, although the hospital was not monitoring this. Staff and patients, we spoke with said there was flexibility with dates and times so people could access the service at a time to suit them.
- General plain x-ray services operated both a booked appointment system and general walk-in service to allow for patients attending outpatient appointments to have plain x-rays on the same day as their outpatient appointment.
- Staff told us diagnostic test results were available within seven days, although most were reported on between 24 and 48 hours. Reports were sent to the referring clinician.
- Did not attend (DNA) rates were not monitored by the service. Staff told us the number of appointments unattended were minimal.
- Referral to treatment time is the term used to describe the period between when a referral for treatment is made and the date of the initial consultation or treatment. The diagnostic imaging test waiting times for patients waiting six weeks or more from referral to a diagnostic test form April 2017 to July 2018 was 0%.

Learning from complaints and concerns

- **It was easy for people to give feedback and raise concerns about care received. The service treated**

concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

- There was information in the department and main reception in the hospital about how to complain or raise concerns.
- The hospital analysed and discussed complaints during management meetings, the quality and risk committee and medical advisory committee. Staff told us site and cross site wide complaints were discussed in departmental meetings.
- There had been one complaint about diagnostics and imaging in the last 12 months. We saw that the issues raised had been fully investigated. An open explanation and apology were provided to the patient as well as offering appropriate solutions. We saw learning from the complaint had been shared with staff and from concerns raised changes had been made. The learning from the complaint had been shared with the local trust which used a similar system of working.
- Complainants were asked if they wished to be involved in the patient forum, so they could continue to share their experiences and be involved in reviewing and shaping service provision.

Are diagnostic imaging services well-led?

Good

This is the first time we have rated this service. We rated it as **good.**

Leadership

- **Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**
- There was compassionate, inclusive and effective leadership at all levels. Leaders at all levels demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care.
- Staff told us the department manager, matron and hospital director were approachable and responsive which enabled them to confidently raise concerns and suggest ideas for improvement.
- The diagnostics manager managed the diagnostics department. They were responsible directly to the matron and were part of the hospital's head of department management team
- The diagnostics manager also received support and clinical accountability by Nuffield's clinical development lead for diagnostic imaging.
- There was a clinical director and chief nurse for the whole provider group in the United Kingdom. There was also a clinical development lead for diagnostic imaging for the UK.
- The department manager told us they were well supported and represented by the senior management team. They told us there were positive working relationships with other diagnostic imaging department managers within the Nuffield group of hospitals.
- The diagnostic manager had worked for the service for several years and had been the department manager for two years.
- There was a radiologist representative on the medical advisory committee representative.
- There was an effective and embedded system of leadership development and succession planning. The hospital had a future leaders programme. This was a 16-month programme where participants were given a day a week over this time to participate in the programme.
- The diagnostics manager gave us examples of staff developing within their role and taking on additional responsibilities such as audit.
- We saw both the diagnostics manager and deputy manager were appointed from within the service having been supported to develop into these roles.

Good

Diagnostic imaging

Vision and strategy

- **The service had a vision for what it wanted to achieve. The vision and strategy were focused on sustainability of services.**
- The values of the Nuffield Hospital North Staffordshire and were shared by staff of the diagnostics department. The values were: C- care, A- aspirational, R-responsive, E-ethical.
- Staff attended sessions regarding Nuffield values and beliefs, 'being our best', led by North Staffordshire senior management team giving staff the opportunity to discuss Nuffield Health beliefs and values.
- The Nuffield values were discussed during the recruitment process and induction for new staff and within appraisals of employed staff. We saw these values were part of staff everyday working within the department providing quality patient care.
- Staff were clear on the development of the service which had recently included new digital x-ray equipment. The manager told us the fluoroscopy room was not fit for purpose and equipment needed replacement to develop this room for other new and developing procedures which focused on sustainability and cost-effective patient care. A business case had been unsuccessful, and a subsequent business case has since been resubmitted.

Culture

- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**
- Staff told us they were proud to work in the department. They felt there was a good team working culture and that they were respected and valued.
- There was a strong team-working approach across the hospital. New staff met all heads of departments during their induction to ensure they understood the importance and roles if each team.
- Staff had a positive 'can do' attitude to patient care. Patients were the focus of the service and wherever possible, care was delivered around the individual needs of patients.
- We saw information was available on staff noticeboards about 'Speaking up'- 'tell us if you see or hear something at work which makes you feel uncomfortable- it is important to report it'.
- All staff we spoke with felt able to raise any concerns and speak out about any victimisation or abuse if they witnessed or experienced any. We saw concerns raised by staff had been thoroughly investigated and appropriate actions were in place to address their concerns.
- Managers encouraged learning and an open culture. Staff told us they were supported and encouraged to report incidents and raise concerns. Information about duty of candour were displayed within the department.
- Team away days were held to help build effective working relationships. Staff told us about taking part in a trip to an escape room. The focus of this away day was to show that teams do not perform well when they work in isolation.
- Nuffield operated a values recognition scheme were staff could nominate each other for recognition and awards. These were displayed in staff areas with nomination cards for staff to complete.
- Long service was celebrated within the hospital and the service. Several staff members had received long service awards which included one member of staff with a 30-year awards and two staff members had 10 year awards.

Governance

- **Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**
- All staff we spoke with understood the management structure at the hospital and knew who they were accountable to.

- There was robust department/ ward to board and board to department/ ward governance arrangements in place.
- Board meeting minutes showed they had oversight of the service's performance against quality and safety measures. We saw that they were aware of areas that required improvement, such as compliance with some mandatory training topics and they had agreed a suitable recovery plan to address this.
- The matron for the hospital took the lead and captured clinical data from the central database to present the clinical governance quarterly and annual reports to the senior management team. These reports identified trends and variances of patient numbers, generating an incident report when a variance was noted. The report included complaints, incidents and patient satisfaction survey results. A comparison was made with previous reports and other hospitals in the group including readmission rates and extended lengths of stay. The clinical governance report was also shared at the Medical Advisory Committee (MAC) and Quality and Safety Committee.
- The diagnostics manager as head of department produced a monthly report for the matron and hospital director of staff, which identified risks, complaints/ concerns and activity of the department.
- There were monthly heads of department meetings. Patient appointments and waiting times, risks, incidents, complaints and staffing were discussed during these meetings and identified actions were flagged and followed up.
- There were staff meetings every two months which were held on different days to accommodate part time staff. The manager said that they would be trying to meet every month. There was a standard agenda template and agenda items included departmental updates, operational matters, governance issues. Team meeting minutes showed that incidents, infection prevention and staff development were discussed.
- The clinical lead for radiology was also the lead for radiology governance. They provided radiology staff with information on performance, standards of practice, development of practice and sharing radiology incidents both within Nuffield Hospitals and more widely.
- There were quarterly radiation protection committee meetings. The national clinical lead for diagnostic imaging attended these meetings. We saw minutes of the last meeting held on 28 March 2019. Discussion included feedback from radiation protection advisors (RPA) report for Nuffield diagnostics services, radiation protection supervisors report which was an amalgamation of findings from all Nuffield radiology departments, adverse incidents reports equipment replacement programmes.
- There were quarterly regional radiography meetings attended by diagnostic managers, picture archiving and communication system (PACS) manager and the national clinical lead. These meetings shared diagnostic incidents and national guidance including changes to national guidance.
- The medical advisory committee highlighted actions for consultants about performance, risks, concerns and consultant practising privileges. Individual consultants were able to highlight issues and request to commence new procedures at the hospital. The MAC meeting minutes were sent out to all consultants with practising privileges.

Managing risks, issues and performance

- **Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.**
- Managers and teams used systems to monitor and manage performance effectively. This included compliance with agreed quality improvement goals, such as; ensuring staff gave appropriate health promotion advice to patients who smoked. Feedback about performance was shared appropriately with staff to thank them for their work and/or share plans for improvement.
- Performance issues were escalated to the appropriate committees and the board through clear structures and processes. This included concerns about

individual staff where records showed that concerns about individual staff members were appropriately reported, managed and investigated to protect patients from any risks associated with poor or unsafe performance

- Clinical and internal audit processes functioned well and had a positive impact on quality governance, with clear evidence of action to resolve concerns. We saw that several audits were completed within the diagnostics department by staff, the patient's forum and the provider. This included; medicines audits, records audits and provider led quality assurance visits based on the CQC five key inspection questions (safe, effective, caring, responsive and well-led).
- There was an effective and comprehensive process to identify, understand, monitor and address current and future risks. Staff knew how to identify and escalate relevant risks and issues and identified actions to reduce their impact. A risk register for the hospital was maintained that incorporated the risks (when appropriate) for the diagnostics department. This fed into an overall location risk register and which had oversight from the board.

Managing information

- **The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**
- There were robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. 97% of eligible staff at the hospital had completed information governance training.
- Staff could access patient information as and when required. They used paper based and electronic patient records that contained detailed patient information from a patients first outpatient appointment to their discharge. Work was in progress to introduce a new electronic health care record that would further improve communication and continuity of care.
- Patients were supported to access the information needed to make decisions about their care.
- Staff could access information such as policies and procedures in paper and electronic format. The policies we viewed were up to date and based on current evidence.
- Staff received helpful performance data on a regular basis, which supported them to adjust and improve performance as necessary. This included the sharing of quality and performance reports and improvement plans.
- The registered manager ensured that data or notifications were consistently submitted to external organisations as required. This included the reporting of significant events, such as; serious injury or safety incidents to CQC as required and without delay.
- There was a secure electronic system for transfer of images from other hospitals including NHS trusts.

Engagement

- **Leaders and staff actively and openly engaged with patient andstaff to plan and manage services.**
- The hospital had a patient's forum which met every three months with the matron. The group shared patient experience and reviewed quality and environmental issues.
- Staff engagement with senior managers was undertaken in a variety of ways. There were monthly coffee mornings with the hospital director, staff away days, newsletters and information on noticeboards alongside team meetings and email contact. Staff were encouraged to share ideas about possible improvements.
- The management team and other leaders consistently engaged with the staff through a variety of communication methods to ensure their views on care and treatment were obtained and they were updated about best practice and changes to policies and processes.
- Staff also worked with and involved commissioners where appropriate to advocate for patients and support them to receive the care and treatment they required.

Good

Diagnostic imaging

Learning, continuous improvement and innovation

- **All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.**
- Staff were supported to develop their skills and improve patient care. This included the diagnostics manager who was reviewing diagnostics equipment to replacement equipment across the Nuffield Group of Hospitals was high quality, provided excellent performance and was cost effective.
- Staff were empowered to improve patient care. The business case for the fluoroscopy room included new equipment which would treat patients who currently would have a hysterectomy to receiving treatment without the need for surgery.

Outstanding practice and areas for improvement

Outstanding practice

- The service worked proactively with other organisations to improve the health and wellbeing of the local community. Staff from outpatients were involved in the provider's, 'Schools Wellbeing Activity Programme' (SWAP), which was designed to empower students to improve their wellbeing. This programme focused on four key themes with the aim of educating children and young people on physical activity, healthy diets, sleep hygiene and emotional wellbeing and resilience.
- The service hosted regular, inclusive and free health promotion and education sessions. These were called, 'come and see our experts' sessions. These sessions focused on health promotion and education and comprised of presentations and/or one to one advice sessions (not consultations) on specific conditions such as, the menopause, breast care, heart disease and joint care. The sessions were advertised within the local community and were available for anyone to book onto.
- An inclusive, holistic and localised approach was used with patients who were due to undergo planned joint replacements. Patients were invited and encouraged to attend a 'pre-habilitation' programme which had been developed in response to patient need as staff had identified that a number of patients who had received joint replacements were surprised about their pain and anxiety pre and post operation, which may have contributed to a longer length of stay in hospital post operation. The programme consisted of a group-based education session which aimed to educate patients about their pre and post operation needs and the operation itself.
- Information about care and treatment was presented to people in a format that supported them to promote effective recovery. In addition to written and pictorial information about post-operative recovery and rehabilitation, patients were able to access physiotherapy exercises in a video format.
- All patients were offered the opportunity to participate in the, 'recovery plus' programme. This was provided to private patients as part of their care and treatment, but also offered to NHS patients at a reduced cost. It included membership at a local gym linked to the provider where patients could continue to receive ongoing rehabilitation with personal trainers and physiotherapy review.
- Managers evidenced how they had proactively listened to and acted upon the concerns raised through an informal complaint. This included the innovative development of a new service aimed at supporting patients with weight reduction and management if they had been identified as unsuitable for immediate surgery due to their weight. This service was to be offered to private and NHS patients which meant an inclusive approach had been taken. The complainant had been invited to trial the new service and were very happy with the way their concern had been managed as this had led to a significant planned change in patient experience.
- There was an effective and embedded system of leadership development and succession planning. This was known as the Nuffield future leaders programme and was a 16-month programme where staff were given protected time to participate in the programme.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should explore how to evidence that all staff have understood and can apply the requirements of the Mental Capacity Act 2005.
- The provider should continue to make improvements to the outpatient and diagnostic department environments so they are dementia friendly.

Outstanding practice and areas for improvement

- The provider should continue with the implementation of the observational audit of the Five Steps to Safer Surgery checklist to improve staffs' compliance.
- The provider should consider monitoring and recording the number of appointments patients did not attend (DNA) in diagnostics and imaging.