CircleReading

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The Circle Reading hospital is one of three hospitals provided by the Circle group in England. It is located on the outskirts of Reading, Berkshire. On-site facilities include inpatient beds, comprising 29 inpatient bedrooms (one bedroom is a double) and 20 day case 'Pods'. The hospital has five operating theatres, three of which have laminar flow. There is an endoscopy suite within the theatre complex, as well as a suite of consulting and treatment rooms, and an imaging department offering x-ray, ultrasound and scans. The hospital also has a pharmacy on site.

The Circle Reading hospital provides a range of medical, surgical and diagnostic services to patients who pay for themselves, are insured, or are NHS funded patients. Services offered by the hospital include orthopaedics, spinal, general surgery, gynaecology, ENT, ophthalmology, endoscopy, physiotherapy and diagnostic imaging.

The Circle Reading hospital was selected for a comprehensive inspection as part of our routine inspection programme. The inspection was carried out using the Care Quality Commission's new inspection methodology.

The announced inspection took place on 15 and 16 August 2016, followed by a routine unannounced visit on the 25 August 2016. This was an inspection of all core services provided at the hospital, surgery and outpatients/diagnostic imaging. The endoscopy service was inspected under the surgical core service.

Our key findings were as follows:

Are services safe at this hospital?

By safe, we mean that people are protected from abuse and avoidable harm.

- Patients were protected from the risk of abuse and avoidable harm across all inspected services.
- Staff reported incidents and openness about safety was actively encouraged.
- Incidents were monitored and reviewed and staff could demonstrate learning from these.
- Clinical areas were visibly clean and tidy.Hospital infection control and prevention policies were followed and these were regularly monitored, to reduce the risk of spread of infections.
- Staff received appropriate training to be able to safely undertake their roles, and were supported in keeping their skills up to date.Staff received regular appraisals and were supported to undertake further learning.
- Equipment was maintained and tested, in line with manufacturer's guidance.There were appropriate checks and maintenance on the hospital building and plant.
- Medicines were stored securely.
- There was regular monitoring of patient records for accuracy and completeness.Patient records were stored securely and were available when needed.
- Staffing levels and skill mix were planned, implemented and reviewed to keep patients' safe at all times. There was a resident medical officer in the hospital 24 hours a day seven days a week.
- When things went wrong patients were given a full apology.However, not all steps of the duty of candour legislation were always carried out.

Are services effective at this hospital?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

- There was a lack of evidence based care and use of national guidelines around the starving of surgical patients.Staff did not have access to national guidance around this to enable them to advocate for patients.
- Although staff demonstrated understanding of consent, and the implications of the Mental Capacity Act, they sometimes had limited understanding of the deprivation of liberty safeguards (DoLS).
- There was evidence of local and national audits, including clinical audits and other monitoring activities such as reviews of services.However, WHO checklist audits had not been completed in the radiology department.
- Information about patient's care and treatment, and their outcomes, was routinely collected and monitored.
- Patient outcomes were in line with the national average, and there were a low number of patients that required to be transferred to other hospitals. There were low numbers of unplanned readmission of patients.
- The staff were competent to carry out their roles.Staff were given time to undertake training, and their competence was checked.
- The hospital submitted data to the National Joint Registry and information to NHS England surgical site infection surveillance.
- Practicing privileges were reviewed robustly and regularly: they were removed from consultants who did not provide suitable assurance of revalidation.

Are services caring at this hospital?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

- Staff provided care that was compassionate and treated patients with dignity and respect at all times.Feedback we received from patients and those close to them was positive.
- Staff spoke about developing and promoting good relationships with patients and having the time to care for them to a high standard.
- Patients anxious about surgery were given time and information, and their individual needs and preferences were always taken into consideration. Patient's family's needs were also considered.

Are services responsive at this hospital?

By responsive, we mean that services are organised so they meet people's needs.

- Services were planned and delivered in ways which met the needs of the local population. Patients told us that there was good access to appointments, and these were at times which suited their needs.
- Waiting times, delays, and cancellations were minimal and managed appropriately. Facilities and premises were suitable for the services being delivered.
- Patients were given written information to support them through the pre and post-operative period.However, these were not available for any patients whose first language was not English.
- Patients discharge was planned for as soon as they were admitted to hospital, and the length of stay was flexible if required.
- The hospital monitored patient waiting times; these showed that 90% of patients began treatment within 18 weeks of referral.
- The hospital had a robust system for learning from complaints and concerns. However, patient information on how to make a complaint was not readily available on the wards.

Summary of findings

- There was openness and transparency in how complaints were dealt with.

Are services well led at this hospital?

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- There was a supportive culture and staff felt empowered to raise concerns to keep patients safe.
- Visions and values of the hospital were devised in partnership with staff.Staff could talk about the values and ethos of the hospital and were proud to work there.
- The culture was open and staff felt that they had the ability to prevent harm to patients through the use of 'Stop the Line'; this was a mechanism by which staff could stop a procedure for immediate review by a senior member of staff. Staff said they did not feel that there would be any repercussions for using this mechanism.
- There were robust systems in place for identifying and managing risk.Risks were recorded and mitigations put in place.
- Staff were encouraged to escalate concerns around patient safety using 'Stop the Line', we were given several examples of this in action.

Our key findings were as follows:

- The hospital was well led by managers that fostered an open culture among staff to report risks to patient safety.
- The hospital was clean and well maintained, staff followed infection control procedures and this was checked regularly.
- There were an appropriate number of suitably qualified staff to look after patients safely.
- Patients were given food and drinks when they wanted them, and as appropriate to their specific needs.

We saw several areas of outstanding practice including:

- Privacy and dignity arrangements for patients undergoing endoscopy were excellent offering them a 'pod' with ensuite facilities.
- There was a domiciliary food delivery service for patients that had undergone surgery.

However, there were also areas of where the provider needs to make improvements.

Importantly, the provider must:

- Ensure that statutory notifications are always reported to the Care Quality Commission in a timely way.
- Ensure that the Duty of Candour process is fully completed after an incident involving patient harm.

In addition the provider should ensure:

- Resuscitation equipment for use with children should be removed from trolleys, as there is a risk of confusion about what equipment to use in an emergency.
- Checks of defibrillators should include a record of a shock test in case the equipment should fail to self-record this.
- Fluid balance charts for patients, especially those having intravenous fluids, should always be accurately completed.
- WHO checklist audits in the radiology department are completed.

Summary of findings

- Staff are trained in Duty of Candour and the application of this duty is monitored.
- Patient leaflets are available in the imaging and diagnostic department.
- The space in the imaging and diagnostic department is reviewed for bed patients, and a standard operating procedure is in place.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	Overall we rated this service as good because: Staff monitored patient safety; they investigated incidents and shared the learning to improve care. All the areas we viewed were visibly clean and well maintained. Equipment was available for staff, and there were regular safety checks on equipment and the environment. Consultants gained consent from patients during the initial consultation and again on the day of surgery. Patient records were well structured and staff completed all the relevant sections with few exceptions. Staffing levels were sufficient to meet the needs of the patients. Doctors were available to provide care for patients 24 hours a day. The service had competent staff who worked well as a team to care for patients. Staff told us training was available and they were given time to attend. Staff were up to date with their mandatory training and understood the safeguarding policies and procedures for adults. The hospital gave discharge information to patients when they went home and sent it to their GPs within 48 hours of discharge. The service had policies and guidance to ensure staff provided care and treatment that took account of evidence based standards and procedures, except with regard to starving pre-operative patients. The hospital reported, reviewed, and benchmarked patient outcomes against other hospitals within the Circle group. Staff supported and treated patients with dignity and respect, and the patients were involved in decisions about their care and treatment. Patients told us they received enough information and were satisfied with the care and treatment they received. Information leaflets were available about the hospitals services; however there was limited access to information for patients whose first language was not English. There were appropriate governance structures in place with committees for clinical governance, health and safety, infection control, medicines management.

Summary of findings

Outpatients and diagnostic imaging

Good

Overall, this service was rated as good. We found outpatients and diagnostic imaging (OPD) was good for the key questions of safe, caring, responsive and well-led. We did not rate effective as we do not currently collate sufficient evidence to rate this.
There were appropriate systems in place to keep patients safe. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. There were well defined and embedded systems, processes and standard operating procedures to keep patients and staff safe and safeguarded from abuse. Staff received up-to-date training in all safety systems.
Patients' care and treatment was planned and delivered in line with current evidence-based guidance, best practice and legislation. There was evidence of local and national audits, including clinical audits and other monitoring activities such as reviews of services. Staff were qualified and had the appropriate skills to carry out their roles effectively, and in line with best practice. Staff were supported to deliver effective care and treatment, through meaningful and timely supervision and appraisal.
We observed that staff were caring, kind, compassionate, and treated patients with dignity and respect. Feedback from people who use the service and those close to them was positive about the way staff treated them. Staff demonstrated they were passionate about caring for patients and clearly put the patient's needs first, including their emotional needs. Patients were positive about the care they received from staff, access to appointments and the efficiency of the service as a whole.
Staff managed and scheduled clinics appropriately. This ensured good availability of appointments for patients across all specialities. Services were planned and delivered in a way which met the needs of the local population. Waiting times, delays, and cancellations were minimal and managed appropriately. There was openness and transparency in how complaints were dealt with.
There was a clear statement of vision and values, which was driven by quality and safety. Staff knew and understood the vision, values and strategic goals.

Summary of findings

There was a culture of collective responsibility between teams and services. Information and analysis was used pro-actively to identify opportunities to drive improvements in care.

Summary of findings

Contents

Good

Circle Reading

Services we looked at

Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to CircleReading

Circle Reading is a purpose built hospital that opened in August 2012. It is an independent sector hospital providing elective surgical care to the population of Berkshire and the surrounding counties. It is part of the Circle group of five hospitals.

Circle Reading consists of 29 inpatient bedrooms (one bedroom is a double) and 20 day case 'Pods'

The hospital treats both private and NHS patients.

Specialities treated include: orthopaedics, spinal, general surgery, gynaecology, ENT, ophthalmology and endoscopy. It has recently stopped providing paediatric surgical and outpatient services.

We inspected the hospital as part of our comprehensive inspection programme.

The Registered Manager was Paula Elizabeth Naylor, registered on 11 May 2016.

The Nominated Individual is Massoud Keyvan-Fouladi, registered 9 July 2012.

Our inspection team

Our inspection team was led by:

Inspection Lead: Moira Black, Inspection Manager, Care Quality Commission (CQC)

The team included three CQC inspectors, an inspection manager and a variety of specialists: these included a vascular surgeon, radiographer and a senior nurse with board level experience.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

We received information and data from the hospital as well as national data. We took written feedback directly from patients in the period before the inspection visit. We also sought information from the hospitals NHS partners and commissioners. During the inspection, key staff were interviewed. We spoke with staff, patients and their relatives during the inspections.

Information about CircleReading

Between April 2015 and March 2016 60% of inpatients and 49% of outpatients were NHS funded.

Hospital activity between April 2015 to March 2016:

- 5972 day-case inpatients
- 2029 overnight inpatients
- 7928 visits to theatre
- 31,275 outpatients (first attendance)
- 39,130 outpatients (follow up)

Most common outpatient department specialties:

1. Allied Health Professional Episode 15.97%

Summary of this inspection

2. Ear Nose and Throat 6.34%
3. Gastroenterology 1.73%
4. General Surgery 3.87%
5. Gynaecology 5.17%
6. Nursing Episode 11.44%
7. Ophthalmology 2.62%
8. Orthopaedics 29.40%
9. Radiology 18.69%

The accountable officer for controlled drugs was Paula Elizabeth Naylor.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We found that patients were protected from the risk of abuse and avoidable harm across all inspected services. Staff reported incidents and there was an open culture that encouraged staff to report safety incidents. Incidents that occurred were monitored and reviews carried out, this allowed staff to learn from these events. This learning was shared across teams and departments.

The hospital was visibly clean, tidy and well maintained. Staff followed the hospital infection control and prevention policies, and senior staff monitored compliance against these, to reduce the risk of spread of infections.

Staff received the training they needed to be able to safely undertake their roles, managers supported staff in keeping their skills current. All staff received a regular appraisal, and were supported to undertake further learning.

The hospital's equipment was clean, maintained and tested. There were appropriate checks and maintenance on the hospital building and environment. We found that medicines were stored securely and appropriately across all departments.

The hospital could demonstrate there was regular monitoring of patient records to ensure high standards of accuracy and completeness. Confidential patient records were available when needed and were stored securely.

There were sufficient planned staffing levels and skill mix to keep patients' safe at all times. There was a resident medical officer in the hospital 24 hours a day, seven days a week.

When things went wrong patients were given a full apology. However, not all steps of the duty of candour legislation were always carried out.

Are services effective?

Requires improvement

We found there was a lack of evidence based care and use of national guidelines around the starving of patients prior to surgery. Staff did not have access to appropriate national guidance about pre-operative starving to enable them to advocate for patients.

Staff demonstrated understanding of consent, and the implications of the Mental Capacity Act. However, some staff had a limited understanding of the deprivation of liberty safeguards (DoLS).

Summary of this inspection

We found evidence of a local audit programme and the hospital contributed to national audits. This included clinical audits and monitoring activities such as reviews of services. However, five steps to safer surgery (WHO) checklist audits were not completed in the diagnostic imaging department.

The hospital collected and monitored information about patient's outcomes, care and treatment. Patient outcomes were in line with the national average. There were a low number of patients that needed to be transferred to NHS hospitals after treatment. There were also low numbers of patients that required to be readmitted to the hospital.

We found evidence that staff were competent to carry out their roles. Staff were given time to undertake training. After they had been trained staff competence was checked.

The hospital submitted data to the National Joint Registry about the outcome of operations, and information to NHS England about the incidence of surgical site infections.

The practicing privileges of consultants were reviewed regularly; these were removed from consultants who did not provide suitable assurance of revalidation.

Are services caring?

Good

Staff provided patients with compassionate care and always treated patients with dignity and respect. We received positive feedback from patients and those close to them about the care and treatment they had received at the hospital.

Staff told us about the importance for them of developing and promoting good relationships with patients. Staff felt they had the time to care for their patients to a high standard.

Patients that were anxious about surgery were given time and information by staff to reduce this. The patients' individual needs and preferences were always taken into consideration. The needs of the patients' family were also taken into consideration.

Are services responsive?

Good

The hospital planned and delivered services in ways which met the needs of the local population. Patients told us that they had good access to appointments, and these were offered at times to meet their needs.

Waiting times, delays, and cancellations were minimal and were managed appropriately. The premises and facilities provided were suitable for the services being delivered.

Summary of this inspection

Patients were given written information about care and treatment they could expect before treatment and afterwards. However, these were not available for patients whose first language was not English.

Planning for patients discharge was started as soon as they were admitted to hospital, the length of stay was flexible if needed.

The hospital monitored waiting times for all patients; data showed that 90% of patients began their treatment within 18 weeks of a referral.

The hospital had a robust system to ensure there was learning from complaints and concerns raised by patients. However, patient information on how to make a complaint was not readily available on the wards. Complaints were dealt with in an open and transparent way.

Are services well-led?

Good

The hospital was well led by managers that fostered an open culture among staff to report risks to patient safety; staff were empowered by this to raise concerns.

The vision and values of the hospital had been devised in partnership with the staff. Staff were able to talk about the values and ethos of the hospital, and told us they were proud to work there.

There was an open culture and staff felt that they had the ability to prevent harm to patients through the use of 'Stop the Line'; this was a mechanism where any member of staff could stop a procedure to allow an immediate review by a senior member of staff. Staff told us there would be no repercussions for using this mechanism. During the inspection staff gave us several examples of where 'Stop the Line' had been used.

The hospital had robust systems in place for identifying and managing risk. Risks were recorded and these were effectively mitigated to keep patients safe.

Good

Surgery

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

Summary of findings

Overall we rated this service as good because:

- Staff supported and treated patients with dignity and respect, and patients were involved in decisions about their care and treatment.
- Patients described a high standard of compassionate and competent care by nurses, allied health professionals and medical staff.
- Staff responded compassionately when patients needed help and supported them to meet their individual needs when required.
- Staff monitored patient safety and investigated incidents and shared learning to improve care.
- All areas we observed were well organised and visibly clean.
- Consultants gained consent from their patients during the initial consultation and this was checked again on the day of surgery. Patient records were well structured and completed to a high standard with few exceptions.
- Staffing levels were sufficient and were planned and maintained to safely meet the needs of patients. The hospital had competent staff who worked as an effective team to care for patients. Staff told us that they were supported with training and were given time to attend. Staff were mostly up to date with their mandatory training and understood the safeguarding policies and procedures for vulnerable adults.
- Medical staff were available to provide care for patients 24 hours a day. The hospital gave discharge information to patients and also sent this information to their GP within 48 hours of discharge.
- The service had policies and guidance in place to ensure that staff provided care and treatment that took account of evidence based standards and procedures. The hospital reported, reviewed and benchmarked patient outcomes against other hospitals within the Circle group.
- Patients told us that they received a good standard of information and were satisfied with the care and treatment they had received. Information leaflets were available for patients, however these were not available in different languages for those patients whose first language was not English.
- There were clear governance structures, with appropriate committees for clinical governance, health and safety, infection prevention and control, medicines management, resuscitation, transfusion and radiation protection.

Good

Surgery

Are surgery services safe?

Good

By safe, we mean that people are protected from abuse and avoidable harm.

Overall we rated this service as good because:

- Staff monitored patient safety and investigated incidents robustly when they occurred. There was evidence that learning from incidents was shared.
- All areas we viewed were visibly clean and well maintained. Appropriate equipment was available for staff to use and there were regular checks on equipment and the environment.
- There were safe systems for medicines to be appropriately stored and managed.
- There were systems for monitoring safety these included checks on the environment, equipment, cleanliness and staff adherence to infection control policies.
- Staff completed pre-printed care pathway documentation and five steps to safer surgery (WHO checklist) documentation consistently and accurately.
- We observed good handover practice on wards. Staff were empowered to speak up if they were concerned about patient safety issues through 'Stop the Line'. This was a Circle initiative which enabled any employee to immediately pause any procedure that had potential to put patient safety at risk and escalate for immediate senior staff review.
- Staff across the surgical wards and theatres were generally up to date with their mandatory training at 87%. The local target was 85%.
- There was sufficient nursing staff to meet the needs of patients and provide safe care.

However,

- Senior staff had not always reported statutory notifications to CQC in a timely way due to confusion about who should be responsible for ensuring this was done. This was a single occasion, immediately rectified upon discovery.
- Although staff knew about the duty of candour, not all the requirements of it had always been fully completed. For example, results of investigations had not been shared with families, because families had said they did not "need to know".
- There was a little inconsistency about the equipment held on each resuscitation trolley, and there were occasional incomplete daily checks.

Incidents

- The hospital did not report any never events between the period of April 2015 and March 2016. Never events are serious, wholly preventable patient safety incidents that should not occur if a hospital has implemented the available preventative measures. The occurrence of a never event could indicate unsafe practice.
- Not all incidents and notifications were sent to CQC as is a requirement of the hospitals registration. For example, one serious injury was reported internally in the period April 2015 to March 2016. However, there was no notification of this incident to the CQC until during the inspection when this omission was noted. However, the hospital moved swiftly to address this. There had been an internal misunderstanding about which member of the senior team was responsible for ensuring that all CQC notifications were made in a timely way.
- In another incident, a serious injury was not reported to the senior team by the surgeon in a timely way, and notification of the incident was initiated by the patients GP via the clinical commissioning group. However, the incident was subsequently reported and the lead nurse undertook an initial review of the care pathway documentation and requested further information from the consultant. A full investigation and root cause analysis was undertaken; this included the reasons why the incident was not reported at the time. Appropriate learning from this was shared.
- There were a total of 130 clinical incidents in the period from April 2015 to March 2016. Out of the total number of these incidents, 75% (98 incidents) occurred in surgery or inpatients.
- The rate of clinical incidents was below the average of the 36 independent acute providers that we hold this type of data for. The data provided to us did not include detail of the degree of harm. A total of 146 non-clinical

incidents were reported between April 2015 and March 2016. Out of these 55% (81 incidents) occurred in surgery or inpatients and 15% (22 incidents) in other services.

- All reported incidents and complaints were discussed at the Clinical Governance and Risk Management Committee meeting that occurred monthly. This was evidenced by the meeting minutes we reviewed. Learning from incidents was shared with staff during 'patient hours' a feedback and learning meeting held within each department. Staff told us this was the mechanism where learning from incidents and complaints was shared. We saw examples of minutes of 'patient hour' meetings where an incident was discussed with staff.
- Serious incidents were investigated and reviewed using a root cause analysis (RCA) process. We reviewed three examples of RCAs and found them to be thorough.
- Staff told us that they reported incidents and they could give us examples of when this had been done. This was also demonstrated by the use of 'Stop the Line', a system that was promoted by senior staff. Any member of staff concerned that there was an issue that had potential to put patient safety at risk was able to pause activity, and escalate for senior staff review. Staff told us they felt enabled to instigate 'Stop the Line' and were confident there would be no consequences from doing so.

Duty of candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with had varying levels of understanding about their responsibility under this legislation, and the actions they must take following an incident of avoidable harm to a patient. Staff told us they would always inform the patient and apologise for the incident. However this did not fully complete the legal obligations required, including sharing the outcome of investigation with the patient. The hospital responsively arranged for staff to receive further training about the duty of candour end to end process: this included conversations with the consultant body.

Safety thermometer or equivalent

- The NHS patient Safety Thermometer is a monthly snapshot audit for measuring, monitoring and analysing patient harms and 'harm free' care. All patients whose notes we checked had venous thromboembolism (VTE) assessments completed on admission. Staff also screened patients for MRSA colonisation and carried out risk assessments for pressure ulcers. The ward manager updated the safety thermometer data for NHS patients.
- There were no incidents of hospital acquired venous thromboembolism or pulmonary embolism in the period April 2015 to March 2016.

Cleanliness, infection control and hygiene

- There was no incidence of MRSA or Meticillin Sensitive Staphylococcus Aureus (MSSA), E-Coli or Clostridium Difficile (C.Difficile) in the reporting period April 2015 to March 2016. All relevant patients underwent screening for MRSA before admission to the hospital.
- Data from NHS England for the period April 2015 to March 2016 showed that the hospital had nine surgical site infections during this period.
- All areas inspected were visibly clean and tidy. Hospital infection prevention and control practices were followed and these were regularly monitored by audits, to reduce the risk of spread of infections.
- We observed hand sanitizing gels were available at designated points such as outside entrances and exits. Although there was no information displayed advising visitors to follow the hospitals' infection control processes.
- Infection control audits were carried out and the result of May 2016 audit showed they had scored 100% compliance against their standards.
- We observed that staff adhered to the hospitals infection control policies, staff washed their hands between each patient contact and observed the bare below the elbows uniform policy to minimise the risk of spread of infection. Personal protective equipment (PPE) such as gloves and aprons were readily available for staff in all clinical areas and these were used as required.
- Equipment in the clinical areas we checked was visibly clean and 'I am clean' stickers identified that items had been cleaned and were ready for use with patients. In the operating theatre, there was a clear process for the management of clean and dirty instruments. Senior staff

told us that all used instruments were collected at least twice daily as these were sterilised off site. Dirty or used instruments were managed appropriately; we observed these were kept in the dirty utility room and wrapped in clear plastic awaiting collection.

- The rate of reported infections during primary hip arthroplasty and primary knee arthroplasty procedures from April 2015 to March 2016 were slightly above the average of NHS hospitals recorded from April 2010 to March 2015. However, the rate of infections for spinal surgical procedures was lower than the NHS average.

Environment and equipment

- Resuscitation equipment we inspected had been checked, but records were not always completed to demonstrate that this occurred daily. For example, the defibrillators had an automatic shock check function that automatically recorded data. This relied on the machine working correctly to store this assurance data. However, there were not always print outs of manual checks of the defibrillators filed to provide evidence that a test had been completed each day.
- There was inconsistency in relation to resuscitation equipment as not all the trolleys carried the same equipment. The hospital had stopped providing care to children at the end of July 2016. However, some paediatric equipment remained on the resuscitation trolleys, such as infant defibrillator pads and child self-inflating breathing bag. The inconsistency in the resuscitation equipment provided posed a risk of confusion of what should be used in an emergency situation.
- On the second floor ward the resuscitation trolley had a paediatric breathing bag and an adult bag which was labelled for training use only. On the second day of the inspection we found that both breathing bags had been removed. Staff told us the adult bag should have been replaced and they would take action to remedy this as the ward was planned for use on the following day. During our visit we saw evidence that this had been done.
- The other resuscitation trolleys were maintained safely and were secured with a tamper evident tag, the serial number of which was recorded as part of the daily check.
- Medical supplies were stored in temperature controlled rooms with secure access.
- In the day surgery area, each patient cubicle or 'pod' had piped oxygen and suction, and a curtain on each for privacy. There were two discrete patient areas in day surgery with a shared toilet for patients. The two areas were maintained as single sex areas. There were two patient cubicles with en-suite facilities; these were mainly used by patients attending for endoscopy procedures.
- Medical equipment required for patients was stored correctly and securely. A check of the wards sterile supplies found that some urinary catheters were beyond the date for safe use. This was escalated during the inspection and they were removed from stock. All other stock checked on inpatient ward areas was found to be in date and ready for use.
- All medical equipment on the wards was safety tested within the last year. There were also asset tags in place to allow each item of equipment to be traced by the facilities management team. This ensured that items of equipment had been regularly checked, serviced and maintained. Equipment used in theatre had records to demonstrate that it had been checked.
- The theatre suite was secure, with electronic staff access only. The facilities such as the operating theatres were spacious and well equipped. There were three theatres equipped with laminar airflow systems; these were used for orthopaedic surgical procedures. A further two theatres were used for other operations. All theatres had a well-equipped anaesthetic room, with controlled drug and appropriate medicines storage, including a refrigerator.
- There was appropriate and secure storage of instruments, equipment and implants required for surgery. These were owned by the hospital that managed stock levels in house. There were no recent incidents where equipment required during operations had to be sent for to other local hospitals.
- All equipment used in surgical procedures was entered onto a computer system to ensure each consumable item and implant used in an operation could be fully traced.

Medicines

- The hospital had a pharmacy on site open Monday to Friday 8.30am to 6pm. There was a lead pharmacist that worked across this and another site, a clinical lead pharmacist, another pharmacist and a technician. There was an on-call service available during out of hours

including weekends. The in-house pharmacist supported the staff with medicines management. In response to patient need and feedback, pharmacy services were provided for extended hours Monday to Friday between 8am and 6pm. For urgent and emergency pharmacy issues there was 24 hour access to an on-call pharmacist.

- Access to the in house pharmacy (where medicines were stored) was restricted by an electronic card entry system.
- Medicines that required refrigeration were stored in a locked fridge, with daily temperature checks carried out. Ward staff stored medicines at recommended temperatures, monitored refrigerator and room temperatures, and took appropriate advice from pharmacy when temperatures were outside recommended ranges.
- Theatres had appropriate temperature controlled medicines storage in each anaesthetic room; these were also subject to daily minimum and maximum temperature checks. The environmental temperature of the theatre suite was centrally monitored by facilities management staff.
- Other stock medicines were stored on the wards correctly, a check during the inspection found stocks to be in date.
- During the inspection we found there was a system for checking controlled drugs on the wards and in two theatres. There were clear records of stock balances and we found no discrepancies. There were appropriate records kept of the administration of controlled drugs. Controlled drugs were stored securely and stock checks occurred daily.
- Patient medicine administration records all recorded known allergies. Patient's own medicines were discussed with them by pharmacists and nursing staff. Pharmacists carried out medicines reconciliation when patients were admitted to hospital for surgery.
- Patient's own medicines were kept in a locked drawer in their room. Additional oral pain relief medicines were given to patients when they had been prescribed, these were stored with the patient's other medicines so that they were available for them to take.
- Regular audits of medicines administration records were undertaken by the pharmacy department, they showed high levels of compliance with medicines management.
- The resuscitation trolley contained emergency drug boxes. Staff checked the expiry dates on the boxes that remained sealed and would escalate to pharmacy if they were approaching expiry. The pharmacy team were responsible for ensuring emergency drug boxes were replenished when they went out of date, staff were aware of this process. Emergency medicines, including oxygen, were available for use and expiry dates were checked to ensure they were safe for use when needed. Emergency trolleys were stocked with the correct medicines for adult resuscitation. Anaphylactic drugs (for the treatment of potentially life-threatening allergic reactions) were also on emergency trolleys.
- We found the in house pharmacy team had robust systems for checking and ensuring that emergency drugs were available as they carried out these checks at the beginning of each month and records were maintained and reviewed on inspection.
- On the wards and in theatres prescription pads and medicines, including controlled drugs were stored securely.

Records

- Patient records were kept in lockable trolleys. These were stored behind the nurses' station. Patient records that had been prepared ready for the patient to have an operation were kept in a box, to maintain privacy and ensure that all documents accompanied the patient into the operating theatre. If these boxes were ever left unattended they were stored in a lockable cupboard. During the inspection we saw that patient records were sometimes left unattended, and the trolleys not locked. However, access to the ward areas was restricted by electronic access cards.
- We saw that patients followed standardised pathways such as total hip replacement or knee replacement. These were personalised through individual risk assessments and care plans.
- We saw evidence in the 12 sets of patient records that we reviewed that pre-operative assessments were completed for all patients that had undergone a surgical procedure. This included the five steps to safer surgery template. We saw that this was used correctly. In two patient records we reviewed, the five steps to safer surgery document was undated. However, we were shown evidence to support that an amended form had

been put into use at the beginning of August 2016. Since this amended form had been implemented all the checklists used after August 2016 were found to be dated appropriately.

- Medical and nursing records in the surgical department were paper based; these were bound and maintained in good order. All of the 12 records we reviewed, except one, were legible, signed and dated. Records contained all the relevant information including discharge letters to the patients' GP.
- We saw evidence of traceability for all supplies used during surgical procedures recorded in the patient care record, this included implants.
- Computer records were secure and were password protected.
- Records and treatment plans were detailed and contained sufficient information about post- operative care that staff told us they referred to. However, we found staff did not always maintain clear and consistent fluid records, including a record of intravenous fluids received by patients post-surgery. This may pose a risk of inconsistent care, and patients receiving intravenous fluids may be at risk of complications of having too much fluid administered.
- When patients were discharged their medical records were stored either at the hospital or securely off-site.

Safeguarding

- There had been no safeguarding concerns reported to CQC between April 2015 and March 2016.
- The hospital had designated leads for adult safeguarding in place. There was also a designated lead for children's safeguarding, although paediatric surgery ceased at the hospital at the end of July 2016.
- Staff had completed level 2 training in safeguarding adults. Information received from the service showed 97% of inpatient, 100% of day care and 80% of theatre staff had up to date training in safeguarding, the corporate provider requirement was 95%. Staff were able to tell us what constituted abuse and said they would report to senior staff in charge. Information from the hospital showed the inpatient lead was also the lead for safeguarding. Information from the CCG indicated that the hospital understood the process of correctly raising a safeguarding concern to the local authority.
- The service provided gynaecology care and clinics. However, Staff we spoke with did not have an understanding of female genital mutilation (FGM) or the statutory action they would need to take to protect these patients.

Mandatory training

- The manager of the theatre suite received a monthly report from human resources about the staff compliance with mandatory training. Across the surgical service 87% (theatres, wards and day surgery) of staff were up to date with their mandatory training.
- Staff received mandatory training on fire safety, manual handling, health and safety, infection control and prevention as well as equality and diversity, the mental capacity act and deprivation of liberty safeguards. There was mandatory basic life support training for all staff at the hospital. Immediate life support was mandatory for those senior staff that carried the cardiac arrest bleep, and records showed that this had been completed.
- The hospitals' resident medical officer (RMO) received mandatory training through e-learning this included; Health & Safety, Child Protection (level 3), data Protection in Health, First Aid Essentials (level 2), personal Safety, child Protection in Health & Social Care, Equality & Diversity, Safeguarding Adults (Level 2) and the Mental Capacity Act. For the completion of this training, the RMO received professional development points annually which they were able to use towards revalidation and appraisal. The RMO was also trained in advanced life support.

Assessing and responding to patient risk

- Early warning scores were used to detect deterioration in a patient. Patient observation charts were filled out correctly and the early warning score was calculated in all the records we reviewed.
- Patients that were deteriorating would be seen by the RMO and the consultant informed before an ambulance was called to take them to the local NHS hospital.
- We observed the use of five steps to safer surgery (WHO checklist) for several operations. The Five steps to safer surgery sets out the steps that should be undertaken during every procedure to help prevent surgical error and patient harm. We also reviewed five records where this had mostly been used fully. There were two examples where the final sign off had not been completed by the operating team.

- A process had been developed for the management of patients who may collapse or become acutely ill. The process was for nursing staff and RMO would attend any emergency on the wards. Patients would be stabilised and/or transferred to the acute trust as required via 999 call system. Staff had completed training in basic life support.
- Risk assessments for falls, venous thromboembolism (VTE), pressure ulcers and nutrition were carried out on admission. However, there was no dementia assessment carried out for patients over the age of 75 years.
- There was a system of screening all surgical patients pre–operatively for risks of potential blood clots and appropriate therapy was prescribed according to risks. We saw that assessments had been completed and patients were prescribed appropriate therapy or preventative measures, such as specific boots or clot busting drugs were prescribed in all the patient records we reviewed.
- Patients' post-surgery pathway included the recording of a visual infusion phlebitis (VIP) score. This is a recognised tool for the evaluation of the condition of intravenous infusion sites and essential to ensure and maintain patient safety. The records showed staff were not consistently completing these checks and did not record the intravenous sites this could impact on the care of the patient, as signs of infection could be missed.
- There was piped oxygen and suction to each patient room on the wards, and each 'pod' in the day surgery unit.

Nursing staffing

- There was no use of a patient acuity tool to assess the dependence of the patients against the available nursing staffing. The inpatient lead said that she had sufficient time to arrange staffing numbers and skill mix for planned surgical patients. The needs of patients would always be assessed against nursing staffing numbers before their booked admission.
- Departmental nursing handover between shifts occurred, using a pre-populated handover sheet. This was undertaken in the nurse's office where patient details could be kept private. Details of patient's operation status and any medical and nursing needs were discussed, as well as planned admissions and discharges.
- The hospital used its own bank for nursing staff to cover shifts. The use of agency staff on the ward areas was very low at around 2%. Where it was used they were given a comprehensive induction.
- There was sufficient staff to provide safe care and treatment across all areas. The regular staff covered absence and leave and also had a bank system which staff said worked well. We observed care was provided in an unhurried manner and staff took time to support relatives.
- There were two resident medical officers (RMOs) who were available to support staff and provided medical cover 24 hours a day. The attending consultants were available to provide support and were accessible to staff and could attend within 30 minutes in an emergency. Any transfers to other hospitals were the responsibility of the patient's consultant that had admitting rights to the local NHS trust.
- The use of bank or agency Operating department practitioners (ODPs) and health care assistants ranged from being above the average of the 35 independent acute hospitals that we hold this type of data for in April and May 2015 and January and February 2016, to being below the average throughout the rest of the reporting period April 2015 to May 2016.
- At the time of inspection there were no vacancies for theatre nurses.
- The rate of vacancies for theatre ODPs and health care assistants was above the average of the 39 independent acute providers that we hold this type of data for. There were two full time posts vacant giving a vacancy rate of 14%.
- The vacancy rate for inpatient nurses was below the average of the 39 independent acute providers that we hold this type of data for. There was a single full time post vacant giving a vacancy rate for nurses as 6%.
- The vacancy rate for inpatient health care assistants was above the average of the 39 independent acute providers that we hold this type of data for. However, this was one full time post giving a vacancy rate of 17%.
- The vacancy rate for other inpatient staff was above the average of the 40 independent acute providers that we hold this type of data for. There were 14 full time posts vacant giving a vacancy rate of 11% in this staff group.
- Theatre nurses had a slightly lower than average rate of sickness, of the 35 independent acute providers that we hold this type of data for.

Good

Surgery

- The rate of sickness for theatre ODPs and health care assistants was also slightly below the average of the 35 independent acute providers that we hold this type of data for.
- The sickness rate for inpatient nurses was mainly below the average of the 36 independent acute providers that we hold this type of data for except for July 2015 and March 2016.
- The sickness rate for inpatient health care assistants varied; but generally was below the average of independent acute providers that we hold this type of data for in the reporting period April 2015 to March 2016.

Surgical staffing

- Consultants carrying out surgical or endoscopic procedures within the hospital are responsible under practising privileges for the care of their patients across 24 hours. This also covered planned and unplanned admissions from the Day Surgery Unit.
- There was an on-call rota for consultant anaesthetists for post-operative patients, although staff told us that many anaesthetists were happy to be called if required to review their patients.
- There is a resident medical officer in the hospital 24 hours a day, seven days a week. They had immediate access by telephone to all consultant staff responsible for their patients.
- The hospital employed two RMOs through a contracted service that was responsible for their employment checks and mandatory training. There was a formal handover process between RMOs as they worked one week on duty and one week off.

Major incident awareness and training

- The hospital had local and corporate business continuity plans with supporting action cards for use in a major incident. The hospital had a major incident plan, and they also ran major incident awareness training for staff.

Are surgery services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as requires improvement because:

- There was a lack of evidence based care and use of national guidelines around the starving of surgical patients. Staff did not have access to national guidance around this in order to advocate for these patients.
- Patient fasting guidelines were not followed consistently, and staff did not have sufficient knowledge of best practice.
- Although staff demonstrated understanding of consent, and the implications for them of the Mental Capacity Act, they had limited understanding of the deprivation of liberty safeguards (DoLS). This was an issue as patients and relatives had to ask to leave the wards as the door release button was not in plain view.

However,

- Staff used an effective system for monitoring patients for signs of deterioration after surgery.
- Patients were given pain relief and the effectiveness of this was checked. There was an audit of pain assessment and medicine administration.
- Patient outcomes were in line with the national average, and there were a low number of patients that required to be transferred to other hospitals. There were low numbers of unplanned readmission of patients.
- The staff were competent to carry out their roles. Staff were given time to undertake training, and their competence was checked.
- Services were provided across seven days, and there was access to the resident medical officer and consultants when patients required this.

Evidence-based care and treatment

- Staff had an awareness of the NICE guidelines; however staff were unable to find a protocol or policy and procedure relating to pre-operative fasting on their computer held central register. There was also no paper

copy available to refer to if needed and to inform staff's practice. This meant that nursing staff did not have the tools to challenge consultants when asked to go against NICE guidelines with regards to patient fasting.

- The nursing staff were not aware of NICE guidelines on pre-operative fasting in order to prepare patients for surgical procedures. They followed the pre-operative assessment information given to patients, and all the patients on the morning list for example were fasted from 6am regardless of the time they were likely to go to theatre. We followed a patient admitted for elective surgery who had not taken any food or fluids from 6am as instructed. This patient did not go to theatre until 2.30pm, which meant they had not received any fluids for eight hours; staff and the patient confirmed this to us. This practice was not in line with the Royal College of Anaesthetists and NICE guidelines which states patients should be permitted to drink clear fluids up until 2 hours before their elective surgery. In the absence of clear protocols and guidelines, patients were at risk of receiving inconsistent care that was not in line with national guidance.
- There was no audit of the duration of fasting for patients undergoing elective surgery carried out.
- The hospital used the modified early warning system (MEWS) to assess a patient's condition using physical observations. This was used to report and respond to any change in a patients' condition post operatively. This was in line with NICE guidance CG50. In patient records we reviewed this was used effectively.
- The hospital used the National Joint Registry to record outcomes for patients that underwent surgery such as hip, knee replacements and spinal surgery. Patient Reported Outcome Measures (PROMS) were collected from patients who had joint replacements and groin hernia repairs. These were all within the expected range of the England average.
- During the period from Apr 2015 to March 2016, the rates of infection during primary hip arthroplasty and primary knee arthroplasty procedures were slightly above the average of NHS hospitals. The rate of infections for spinal surgeries was lower than the NHS average during the same period. There was no evidence of the service using a benchmark against similar service to assess their performance.
- Staff told us they collected data on post-operative wound infection; however they did not know the results of this audit and could not describe any discussion or action taken following these audits.
- A summary of care and treatment was sent to patients' own GP within 48 hours of a patient being discharged from the hospital. This detailed the reason for admission and any investigation results, treatment and discharge medication. A copy of the discharge summary was given to all patients. There was no mechanism for staff to follow up patients post discharge, and staff said that they relied on patients to contact them if they had any concerns about their aftercare.

Pain relief

- Patients were assessed and prescribed pain relief prior to their operation.
- Pain control was not always discussed during their pre-admission assessments. For example, one patient told us the nurse told them they should ask the anaesthetist at the time of admission. However, five other patients that we spoke with said they had adequate pain control and pain relief was available to them when they needed it.
- The staff used a pain assessment tool with a numeric rating scale, where patients rate their pain on a simple scale of 0-10.The staff did not always review the scales for pain relief such as the effectiveness of the pain control given. Records showed this was inconsistently recorded and staff could not be assured patients' pain was managed effectively. There were different numeric scales used which could be confusing for staff and the patients. For example, for the MEWS, staff used scales of 0-3 for pain assessment which was not compatible with the care pathway where they used 0-10. For nausea score; there was scale of 0-3. Staff had recorded 0 for no relief instead of no nausea. Although there was a pain audit carried out, these discrepancies had not been identified.
- There was no visual analogue pain assessment tool which is a nationally recognised tool for people for people with a cognitive impairment.

- Patients that we spoke with were positive about their pain control experience, and they described different types of pain control they had received according to their pain severity.
- A pain audit was carried out monthly, with results feeding into the local medicines management and Clinical Governance and Risk Management Committees. Inpatient ward nurses also reviewed patient risk assessments and care plans which included pain. Audits demonstrated a high level of compliance with the hospitals standard, non-compliance was raised with staff.

Nutrition and hydration

- Patient's admissions were not staggered through the day, which meant patients arrived already starved. Some patients remained without food or water for long periods. Guidance on pre-operative patient starving was not accessible for staff, who did not challenge long starving periods. For example, one patient we spoke with confirmed that they had not had food or fluids for more than six hours prior to their operation.
- A daily report included any individual dietary requirements for patients that were due to be admitted or were already on the ward.
- Fluid balance charts were completed for patients that required fluid balance monitoring. However, we found some fluid balance charts, including those used for patients with intravenous fluids, had not been fully completed.
- A regular drinks round was carried out on the wards six times per day, and patients were able to contact the hospitality staff directly from their bedrooms if they required any additional food or drinks.

Patient outcomes

- The hospital participated in national audits such as patient reported outcome measures (PROMs) for surgery of hips, knees, hands, spines and hernias. PROMS measures the quality of care and health gain received from the patients perspective. Between April 2014 and March 2015 data from PROMS showed the hospital was within the expected range for both knee replacement surgery with regards to the oxford knee score, and hip replacement surgery with regards to the oxford hip score.
- NHS patients were offered the opportunity to participate in the Patient Reported Outcome Measures (PROMS) data collection if they had received treatment for hip and knee replacement or groin hernia.
- The hospital also registered patients that had had joint replacements onto the National Joint Register.
- The hospital monitored outcomes such as transfers out to other hospitals, readmission rates and unplanned returns to theatre.
- There were three cases of unplanned transfer of an inpatient to another hospital between April 2015 and March 2016. The assessed rate of unplanned transfers (per 100 inpatient attendances) was not high when compared to a group of independent acute hospitals which CQC holds this data for.
- There were four cases of unplanned readmission of patients within 28 days of discharge between April 2015 and March 2016. The assessed rate of unplanned readmissions (per 100 inpatient attendances) was not high when compared to a group of independent acute hospitals which submitted performance data to CQC.
- There were two cases of unplanned return of the patient to the operating theatre, one in the period April to June 2015 and another in July to September 2015.

Competent staff

- The Clinical chairman fulfilled a medical advisory function as part of his role. This involved the granting and reviewing of practising privileges for medical staff. New consultants had to provide evidence of qualifications, training and registration and revalidation with their NHS Trust before practising privileges were granted.
- The hospital maintained a list of consultants with practising privileges, this included information about indemnity insurance and review dates and appraisal information. Senior managers ensured that relevant checks were made against the professional register, as well as information from the Disclosure and Barring Service (DBS).
- Resident medical officers had received mandatory training on advanced life support.

- All staff undertook a mandatory induction programme, and worked towards achieving competencies for their role.
- Staff told us that they had sufficient time provided to complete their mandatory training. Staff also spoke positively about being given opportunities for further training if they had identified a need for it through the appraisal process.
- There was a high compliance with appraisals, 95% of nurses working in inpatient and theatre departments had an appraisal between January and December 2016.
- In the same period, 95% of health care assistants working in inpatient and theatre departments, operating department practitioners and other staff had received an appraisal.
- All departments had 'patient hours' these were structured meetings for sharing learning from incidents or complaints; they were also used for clinical learning as well as clinical supervision.

Multidisciplinary working

- During the inspection we observed good multidisciplinary working between different teams involved in patient care and treatment. There was clear communication between staff from different teams, such as the anaesthetist and operating department assistant, theatre and ward staff. Staff described the team as supportive and felt their contribution to patient care was valued.
- The hospital offered physiotherapy for both inpatients and out patients. Physiotherapists were involved in the pre-assessment of orthopaedic patients, and provided patients with advice and education about exercise and walking aids before their operation.
- Physiotherapists worked with post-operative patients to ensure they were recovering as expected. If patients were assessed as requiring equipment to use at home, such as a raised toilet seat or walking aid, the physiotherapist would assess for and provide this.
- Physiotherapists and a sports therapist worked as part of the team on the inpatient wards and in the day surgical unit. If referral was required to Physiotherapy or occupational therapy outside the hospital, staff would write referral letters for patients and discuss post-operative needs with NHS or local authority therapy staff.

Seven-day services

- The hospital offered nursing care seven days a week 24 hours a day. The theatre suite was available for elective surgery between 8am and 8pm Monday to Friday, there were some operating lists on a Saturday.
- The pharmacy is open five days a week but there is an on-call service that is shared with Circle Bath Hospital.
- There is a resident medical officer (RMO) in the hospital 24 hours per day, seven days a week.
- Consultants are on-call for their patients 24 hours a day, during their stay at the hospital. Staff told us that consultants were always accessible to discuss their patients with nursing staff and the RMO. Consultants reviewed their patients every day.
- There were on-call rotas for anaesthetists and radiology, as well as senior managers which were available when staff needed them.

Access to information

- Records were available to all staff involved in providing patient care, this included physiotherapists and pharmacists.
- There was an intranet system via which staff could access hospital policies, standard operating procedures and guidance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed patients being asked for their consent prior to examinations, observations of care.
- Consent forms we reviewed were fully completed, and consent was re-checked if the patient had signed their form at pre-assessment before surgery. Staff told us of an example where a consent form had not been completed correctly and staff halted the operation procedure until this was resolved using 'Stop the Line'.
- Although the wards were secure with card access into wards and departments, we observed patients having to

ask staff to release the door from the wards, as the door release button was not in clear sight. Staff were unaware of the potential for a deprivation of liberty if a patient was not able to leave.

- The hospital had not made any applications for a deprivation of liberty (DoLS).Staff we spoke with did not understand the procedure around the need to make an application for a DoLS, or why patients being unable to leave the unit independently may breach this.
- Patients with a life limiting condition or with a do not attempt cardio-pulmonary resuscitation order were outside of the scope of the criteria for admission and treatment at this hospital.

Are surgery services caring?

Good

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

We rated caring as good because:

- Staff provided care that was compassionate and treated patients with dignity and respect at all times. Patients told us that staff were always helpful and kind.
- Staff spoke about developing and promoting good relationships with patients and having the time to care for them to a high standard.
- Patients anxious about surgery were given time and information, their individual needs and preferences were taken into consideration. The needs of the patient's families were also taken into consideration.

Compassionate care

- Relatives were encouraged and supported to stay with patients and their wishes were respected. Visiting hours were flexible which allowed relatives to support patients. A patient told us they had their family staying overnight following their surgery. They said it was comforting as there was someone close to them at such a time when they were anxious. Relatives also commented to us that the staff were very caring and that nothing was too much trouble.
- Patients anxious about their operation were given time and information to reduce their anxiety. Staff worked together to help patients with their anxiety.
- Patients told us that call bells were answered promptly and that nursing staff had developed good relationships with them and their relatives. They also told us they were treated with the "utmost respect". Another patient commented that the hospital staff ensured their privacy and dignity at all times. Staff were observed to knock before entering patients' rooms on several occasions.
- We saw examples of numerous thank you cards. The patient feedback we received was positive about the care patients received at the hospital.
- The hospitals friends and family test (FFT) scores for NHS patients (in the independent hospital sector) were similar to the England average of NHS patients across the period October 2015 to March 2016. The hospital reported consistently high levels of patient satisfaction at 98%. The FFT survey response rate was variable, being above the England average in October, November 2015 and February 2016 to below the average in December 2015, January and March 2016.

Understanding and involvement of patients and those close to them

- Staff gave patients information about their procedure at their pre-assessment appointment. This included procedure specific information leaflets and a patient information booklet about their stay in hospital. Patients confirmed that they had received an excellent standard of pre-operative information, and had the opportunity to ask staff questions. A discharge letter was provided to the patients GP within 48 hours of discharge.
- Staff discussed care and treatment in detail with patients, including what to expect post-operatively including length of stay, and involved patients in their plans for discharge.
- Patients were consulted on all aspects of their care and treatment. Relatives were involved in care if this was the patients wish. Relatives were able to stay with patients to support them if they wished to.
- We observed staff in the anaesthetic room explaining care and treatment to patients and helping to reduce anxiety.

Emotional support

Good

Surgery

- At pre-assessment appointments patients were given time to discuss any fears and anxieties that they may have about surgery.
- Staff helped patients and those close to them to cope emotionally with their care and treatment. For example, we saw excellent care of a patient in the anaesthetic room before undergoing a joint replacement operation. The patient was escorted to the theatre suite and by a nurse from the ward and there was good hand over communication to the anaesthetist and the OPD. The anaesthetist was supportive and careful to explain what he was doing when placing an epidural.

Are surgery services responsive?

Good

By responsive, we mean that services are organised so they meet people's needs.

We rated responsive as good because:

- Services were planned and delivered in flexible way that met the needs of the local population.
- Patients were given written information to support them through the pre and post-operative period. However, these were not available to be given to patients whose first language was not English.
- Patients discharge was planned for as soon as they were admitted to hospital, length of stay was flexible if required.
- The hospital monitored patient waiting times; these showed that 90% of patients began treatment within 18 weeks of referral.
- Patients were treated as individuals, and their needs and preferences were identified and met by staff.
- The hospital had a robust system for learning from complaints and concerns.

However,

- Staff told us that they did not always receive information about hospital actions after a patient had made a complaint.
- Patient information on how to make a complaint was not readily available on the wards.

Service planning and delivery to meet the needs of local people

- Written information was available in English only and staff told us they would try and get it in other languages but this may take some time. There was no information presented for patients in pictorial formats. This meant patients for whom English was not their first language, or those with learning difficulty may not be able to access written information about their care and treatment.
- There was an information leaflet given to patients regarding monitoring surgical wound infection produced by Public Health England. This contained information in appropriate language to inform patients, and was available in eight different languages.
- There was a day surgery unit that consisted of 20 pods, which enabled patients to have minor procedures or surgery, without having a planned overnight stay in hospital.
- There was a facility available at the hospital to support day care patients who may have an unplanned overnight stay. They were moved to one of the inpatient wards. This ensured that patients were not transferred out and were able to recover before being discharged home.
- Patients who had planned surgery were at times admitted to the day surgery 'POD' if an inpatient bed was not available when they arrived. Staff said they were then transferred to the ward post- surgery. This meant that patients were able to have their surgery as planned and cancellation of surgery was low.
- During the inspection, the hospital was operating at reduced capacity with one ward which had been closed and was opened intermittently to accommodate day cases / overnight stays.

Access and flow

- Patients discharge was planned from admission. This included post-operative physiotherapy and equipment for orthopaedic patients, and discharge summaries were sent to the patient's GP within 48 hours.
- The hospital reported they have cancelled 12 procedures for a non-clinical reason in the last 12 months; of these, nine patients were offered another appointment within 28 days.
- The hospital did not meet the target of 90% of admitted patients beginning treatment within 18 weeks of referral for April 2015 of the reporting period before the targets were abolished (April to May 2015. However, over 90% of

patients began treatment within 18 weeks of referral throughout the rest of the reporting period (June 2015 to March 2016) except in February 2016. Although this performance target had been abolished as a requirement the organisation had continued to use it as a measure.
- There was a monthly report produced by the hospital to provide audit of patient waiting times for treatment. Data was sent to commissioners every month in order to monitor contractual and treatment obligations.
- Operating theatre usage was from 7.30am - 8pm on most days of the week (Monday -Friday and some Saturdays) but could flexibly run until all patient procedures were complete which was sometimes until 9pm.
- The endoscopy suite was used for all endoscopy cases except for those requiring general anaesthesia which are performed in Theatre 4 or 5. It was also used on occasion for minor operations. Operating times were 8am until 6pm or until cases are complete which may be until 7pm.

Meeting people's individual needs

- Although there were dementia champions identified from staff, there was limited awareness of dementia care. This may be due to the hospitals criteria for treating patients, that meant that staff did not have many opportunities to care for patients living with dementia.
- The hospital carried out an audit of patients' documentation and records in April 2016. This showed that of the 10 records audited; the question "Has the need for mental capacity assessment been recorded" was blank in all records which meant this had not been considered.
- There was no evidence that patients aged 75 and over admitted to hospital were screened for dementia using the dementia screening tool. This was not in line with department health and NICE guidelines in identifying patients as potentially living with dementia.
- Staff's knowledge in relation to mental capacity was variable and the service had no lead for dementia. The staff had all had training in dementia, except for those working in the day care unit that would be unlikely to accept a patient with the condition.
- Although there was no special menu for patients with different nutritional requirements, this was dealt with on an individual basis by the chef who visited patients to ascertain their personal requirements.
- There was a domiciliary food delivery service available for post-operative patients. Food could be delivered to the patient's home for the first two weeks of their recovery from surgery. The support this offered post-operative patients through an important time in their recovery was outstanding practice.
- Care plans recorded patient's individual needs and preferences. Patients could have visitors at any time, and relatives or partners were permitted to stay with the patient if that was their wish.
- All Patient rooms were equipped with a shower room that had level access.
- In the day surgery unit there were two patient cubicles with en-suite facilities; these were mainly used by patients attending for endoscopy procedures.

Learning from complaints and concerns

- Staff told us verbal concerns and complaints were dealt with at the time and these would be recorded in patients' notes. There was no system to record verbal complaints that would enable the staff to identify trends in order to develop an action plan or learning.
- The team leads passed all written complaints to the Quality Assurance Lead, but they were concerned that they were not given information about the outcomes of patient complaints.
- There were 22 items of rated feedback for the hospital on the NHS Choices website for the hospital in the reporting period April 2015 to March 2016: 17 patients rated that they were extremely likely to recommend hospital and one rated likely to recommend. Two patients rated neither likely nor unlikely to recommend and a further two extremely unlikely to recommend.
- There were no complaints received by CQC between April 2015 and March 2016. One complaint has been received since in May 2016.
- The hospital received a total of eight complaints from April 2015 to March 2016. One complaint was referred to the health service Ombudsman.
- The assessed rate of complaints is lower at Circle Reading than other independent acute hospitals.
- The Clinical Governance and Risk Management committee reviewed complaints, concerns,

compliments and themes every month. These are also presented in the monthly Business Review Reports, Assurance Dashboards, Chief Medical Officer's Report and Key Performance Indicator Reports.
- There was a clear and robust system for dealing with patient complaints. There was a central complaints log maintained by the Quality and Assurance Lead that was kept up to date.
- Complaints, concerns, compliments and themes were discussed in the hospital leadership team meetings that occurred monthly, and at the quarterly Integrated Governance Committee meetings and within the monthly Executive Board meetings.
- Patients could access information about making a complaint; leaflets were on the main reception desk. However, these were not on display on the wards or day surgical areas, this meant that if in-patients wanted this information they would have to request it from the staff. The hospital website also provided a link to the complaints information leaflet.

Are surgery services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well-led as good because:

- Visions and values of the hospital were devised in partnership with staff. Staff could talk about the values and ethos of the surgical service and were proud to work there. Staff could explain the hospitals' eight point plan known as 'above and beyond'.
- The culture was open and staff felt that they would be able to prevent harm to patients through the use of 'Stop the Line' they did not feel that there would be any repercussions to themselves for using this mechanism.
- There were robust systems in place for identifying and managing risk. Risks were recorded and mitigations put in place.
- Staff were encouraged to escalate concerns around patient safety using 'Stop the Line', we were given several examples of this in action.
- There was an open culture and staff felt empowered to raise concerns to keep patients safe.

Vision and strategy for this core service

- The vision of Circle Reading was articulated in the 'credo' and also in the vision and strategy 8 point plan which is known as 'above and beyond'. This was based on feedback and ideas from the Circle Reading team. The value of partnership was promoted; partnership in action for them was about developing mutually beneficial relationships that improved the quality and experience of care for patients. There was a strong sense that staff tried to meet and exceed patient's expectations on the surgical wards and departments. Staff in the surgical service were clear not only about the corporate vision and strategy but also of that for their individual service.
- Their service vision promoted effective partnership working resulting in high quality patient care, and good business performance, and required everyone to be clear on their roles and responsibilities. Staff at all levels were empowered to go 'above and beyond' in providing services to patients.

Governance, risk management and quality measurement for this core service

- Staff could tell us about the Circle operating system that was designed to identify and mitigate clinical risks. 'Stop the Line' was used by staff when there was a situation that may affect patient care or safety. Following on from this was a 'swarm' where senior staff would quickly come together to examine risks and issues and resolve them together quickly. Learning from these situations was shared with staff at meetings.
- The Clinical Chairman provided a medical advisory function. However, there had not yet been an evaluation of the medical advisory function measured against the previous model of having a medical advisory committee. The clinical chairmen also led the Executive Board meetings and the Clinical Governance and Risk Management committees. These meetings had a standing agenda which included regulatory compliance, practising privileges, incidents and complaints, as well as quality assurance. The hospital used a quality assurance dashboard to enable managers to get an overview of compliance across all departments.
- There was a governance structure and process in place within the surgery division. Governance meetings took

place on a monthly basis and also reported on finance, performance and quality issues within the division. They looked at incidents such as the hospital's acquired infection reports and compliance with hand hygiene audits. However, it was not always clear how the learning from governance meetings was cascaded to the staff. These meetings were minuted and these were shared with staff.

- Staff had access to a range of standard operating procedures (SOPs) for them to refer to, on the wards and in the operating theatre suite these were available on the intranet. The SOPs we saw were within their review date.
- There was a programme of audit; those that we saw were carried out regularly. There were audits for infection control and prevention, environmental audits as well as audit of compliance with the preoperative checks in the WHO checklist and VTE assessment.
- Staff of all grades spoke positively about the support from their immediate team leads and felt they could raise concerns about patient safety or care.
- Systems and processes in place for identifying risks were not always robust, and risks which had been identified during the inspection did not appear on the risk register. For example, we found inconsistency in processes such as checks of resuscitation trolleys. The risk of having additional equipment for paediatric cardiac arrest present on the resuscitation trolleys had not been identified or acted upon. Monitoring systems had not identified these issues.
- There were regular monthly clinical governance and risk meetings. This meeting received reports from subcommittees and documents such as; the risk register, CMO report, key performance indicators, incident analysis reports.
- Staff development was not always pro-active as they worked in discrete areas, and staff were led by consultant's wishes rather than national guidelines, research or innovative practice.
- Protocols were not developed to ensure consistent and safe care such as in pain assessment and fasting.

Leadership / culture of service related to this core service

- The hospital manager had been in post for the five months prior to the inspection. The focus of her concern was in building the business to ensure that the business model was sustainable. The manager was hoping to be able to build closer working relationships with local NHS trusts to help with this. The clinical chair was responsive to the needs of the senior management team and would attend the hospital when required.
- The hospital reports that they have a good relationship with their local commissioners and met monthly with them, and responded to their questions and concerns promptly.
- Staff that we spoke with felt that if they made the decision to use 'Stop the Line' and pause clinical activity in order to prevent mistakes or accidents, that they would be supported. Staff told us they were happy and felt proud to work at the hospital.
- We were told of examples of where consultants practicing privileges were suspended where they chose to go against established hospital procedures, such as not providing appropriate revalidation records.
- The hospital only partially met the requirements related to duty of candour. However, they were responsive in putting staff through additional training when this was highlighted to them during the inspection.

Public and staff engagement

- Staff were involved in devising the 'above and beyond' strategy that was based on the hospitals four part quality system (Circle operating system). This system is an organisational aim to give best patient experience, clinical outcome, best value and the most engaged staff. Staff that we spoke with spoke of the Circle operating system and the 'credo'.
- Staff forums have begun to occur in the five months since the general manager started. Staff also talked about how they valued the 'patient hours' where they were able to discuss care, organisational related issues and improvement. Staff were empowered to suggest and promote new ideas. For example, the chef led the development of the food home delivery service for recovering surgical patients.
- Circle Reading published a monthly Staff Newsletter, this included details of developments within departments, feedback from audit as well as charity events. Such as the hospitals participation in the 'race for life' raising money for cancer research.
- Circle Reading staff attended a local fundraising day and provided members of the public with a range of fruit juices and smoothies, to raise public awareness of the hospital and the services it offers.

- The hospital also ran other events that included bingo nights and raising funds for a local hospice.

Innovation, improvement and sustainability

- The hospital had started the process of pursuing joint advisory group (JAG) accreditation for the endoscopy unit. There were also plans to expand capacity in the day care facility through the introduction of an ambulatory care unit.
- The hospital was also considering employing further consultants (both surgeons and anaesthetists), and developing the role of surgical care practitioners.

Good

Outpatients and diagnostic imaging

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

Information about the service

Outpatient services at Circle Reading cover a wide range of specialities. These include gynaecology, ear nose and throat (ENT), orthopaedics, cardiology, radiology, physiotherapy plastic surgery and gastroenterology. Diagnostic imaging facilities provided by Circle Reading include x-rays, ultrasound, digital mammography screening, pathology testing and magnetic resonance imaging (MRI) scans. Mobile CT scanning services are available offsite and are delivered by another provider and therefore not included in this inspection process.

Between April 2015 and March 2016, the outpatient department at the Circle Reading provided 31,275 new patient appointments and 39,130 follow up appointments. During this period 49% of these patients were NHS funded and the remaining 51% were funded by other sources.

The outpatient department operates between 8am and 8pm Monday to Friday, and on Saturdays between 8am and 4pm. The operating times within diagnostic imaging services is between 8am and 8pm Monday to Friday, with on-call services between 8pm to 8am.

There are fifteen general consulting rooms and two clinical treatment rooms. Minor operations are carried out within the outpatient department and there is a dedicated room for this.

During the inspection we visited the outpatient department and diagnostic imaging services. We spoke with 16 patients and 12 members of staff including, nurses, consultants, radiographers, health care assistants, chefs, administrators and managers.

Throughout our inspection we reviewed hospital policies and procedures, staff training records, audits and performance data. We looked at the environment and at equipment being used. With the patient's permission, we observed care being provided. Before, during and after our inspection we reviewed the provider's performance and quality information.

Good

Outpatients and diagnostic imaging

Summary of findings

Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.

However, some staff had limited knowledge of the Duty of Candour principles.

There were clearly defined and embedded systems, processes and standard operating procedures to keep patients and staff safe and safeguarded from abuse.

Lessons were learnt and communicated widely to support improvement in other areas as well as services that were directly affected.

Patients care and treatment was planned and delivered in line with current evidence based guidance, best practice and legislation. Information about patient's care and treatment, and their outcomes, was routinely collected and monitored.

There was evidence of local and national audits, including clinical audits and other monitoring activities such as reviews of services. However, WHO checklist audits had not been completed in the radiology department. Staff were qualified and had the appropriate skills to carry out their roles effectively, and in line with best practice.

Staff were supported to deliver effective care and treatment, through meaningful and timely supervision and appraisal.

Services were planned and delivered in way which met the needs of the local population. Patients told us that there was good access to appointments and at times which suited their needs.

Waiting times, delays, and cancellations were minimal and managed appropriately. Facilities and premises were appropriate for the services being delivered.

There was a clear statement of vision and values, which was driven by quality and safety. Staff knew and understood the vision, values and strategic goals.

There was an effective and comprehensive process in place to identify, understand and monitor and address current and future risks.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

By safe, we mean that people are protected from abuse and avoidable harm.

Overall we rated this service as good because:

- Openness and transparency about patient safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- However, some staff had limited knowledge of the duty of candour principles.
- There were clearly defined and embedded systems, processes and standard operating procedures to keep patients and staff safe and safeguarded from abuse.
- Lessons were learnt and communicated widely to support improvement in other areas as well as services that were directly affected.
- Improvements to safety were made and the resulting changes were monitored. Staff received up-to-date training in all safety systems.
- Staffing levels and skills mix were planned, implemented and reviewed to keep patient's safe at all times.
- Plans were in place to respond to emergencies and major incident situations.

Incidents

- In all outpatient areas staff were aware of their responsibility to report incidents. Staff reported incidents either via an electronic system or to their manager who logged the incident on the reporting system. Staff we spoke with were confident to report incidents and challenge poor practice by staff at any level. In the diagnostic imaging department, there were clear processes for reporting incidents about the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). Staff were aware of these.
- In the reporting period April 2015 to March 2016, there were 130 clinical incidents reported across the hospital. Out of 130 clinical incident 18% (23 incidents) had occurred in outpatients and diagnostic and imaging. The rate of clinical incidents that took place within OPD was below the average of the 8 independent acute providers that we hold this type of data for.
- In the reporting period of April 2015 to March 2016, there were 146 non-clinical incidents reported across the hospital. Out of 146 non-clinical incidents 29% (43 Incidents) occurred in outpatients and diagnostic and imaging. The rate of non-clinical incidents was above the average of the 34 independent acute providers that we hold this type of data for.
- The rate of non-clinical incidents that took place within OPD was above the average of the 8 independent acute providers that we hold this type of data for.
- We saw evidence that all reported incidents had been investigated and appropriate action taken.
- The hospital reported no serious incidents requiring investigation in outpatients during period April 2015 to March 2016. In same period, there were no deaths and no never events. Never events are serious, wholly preventable patient safety incidents that should not occur if a hospital has implemented the available preventative measures.The occurrence of a never event could indicate unsafe practice.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Senior staff told us they had received information and training on the duty of candour.
- Staff had a limited knowledge of the duty of candour. Although staff we spoke with were able to describe the principles of the duty of candour, and confirmed that they would contact a patient and provide truthful information if errors had been made, they were not aware of the legal process that needed to be followed.

Cleanliness, infection control and hygiene

Good

Outpatients and diagnostic imaging

- All outpatient areas, both waiting rooms and clinical rooms were visibly clean and well maintained. The environment in both waiting areas was light, airy and had a calm atmosphere.
- Hand sanitiser points were available for patients, staff and visitors to use. This encouraged good hand hygiene practice. However, there was no signage to promote hand hygiene to visitors and staff.
- During the inspection staff we observed adhered to 'bare below the elbow' policy to enable thorough hand washing and prevent the spread of infection between staff and patients.
- Personal protective equipment (PPE), such as gloves and aprons, were readily available for staff to use in all clinical areas, to ensure their safety when performing procedures. We observed staff using them appropriately.
- We checked PPE equipment including x-ray protection lead coats during the inspection: they were clean and in good condition.
- There were 'sharps' disposal bins in in all consultation rooms, and we noted that none of these bins were more than half full. This reduced the risk of needle-stick injury.
- In line with current best practise the Circle Reading had a 0% MRSA rate (April 2015 to March 2016), which was achieved through an effective MRSA screening programme. In the same period, there was no incident of E-Coli and no incidence of C.Difficile.

Environment and equipment

- Equipment was visibly clean. The environment was clean and well maintained We saw labels on the equipment with the last service date and review date. They also had an asset number to ensure the item could be tracked if it required servicing or planned maintenance.
- Electrical safety testing was undertaken annually, and we saw records confirming this. Staff we spoke with were clear on the procedure to follow if faulty or broken equipment was found. All repair work was completed by engineer's onsite.
- Staff did not report any concerns regarding availability or access to equipment. Staff told us senior management was supportive of requests for new equipment.
- The housekeeping team managed the disposal of waste. There was clear labelling of clinical waste bins and sharps boxes we checked in clinical rooms with the date they were put into use.

Medicines

- Medicines were stored safely in outpatients. We saw locked medicines cupboards and the keys were held by the lead nurse on duty. Staff we spoke with were aware of who held the keys.
- There were no controlled medicines kept within OPD and Diagnostic Imaging.
- Prescription pads (FP10) were seen to be stored securely and appropriately on-site.
- Prescription tracking systems were in place in accordance with national guidance and appropriate actions had been taken when discrepancies were identified.
- A limited range of To Take Out (TTO) packs were available for a specific clinic, which were dispensed by the pharmacy team.
- Refridgerators to ensure medicines were stored at the correct temperature were locked and temperatures checked daily and recorded.

Records

- At the time of inspection we saw patient personal information and medical records were managed safely and securely. During clinics, all patient records were kept in a locked office and transferred to the consultant when the patient arrived. Staff told us that they had no difficulty in retrieving patient notes for clinic appointments.
- Patients had a digital image taken with their consent on arrival at the hospital.This was to allow the consultant to recognise the patient when they called them for their consultation.

Good

Outpatients and diagnostic imaging

- All the staff we spoke with were aware of their responsibilities around the safe keeping of records and the confidentiality of patient information. Patient identifiable information such as patient records were stored securely in locked cabinets.
- The Picture Archiving and Communications System (PACS) is a nationally recognised system used to report and store patient images. This system was available and used across the Diagnostic Imaging department.
- Image transfers to other hospitals were managed electronically via a secure system.
- Medical records were only permitted to be taken off site by consultants, who were registered as data controllers with the Information Commissioner's Office. This is a requirement of their practising privileges agreement. Consultants were personally responsible for security of records when off site.
- When registered consultants took records off site, the hospital retained a copy to ensure a complete contemporaneous record was available at all times.

Safeguarding

- During the period of April 2015 to March 2016, there had been no safeguarding alerts or concerns reported to the CQC.
- There were safeguarding children's and vulnerable adult's policies in place. However, the hospital had stopped providing services for children at the end of July 2016.
- The hospital had appointed dedicated leads for safeguarding vulnerable adults and children. These staff could demonstrate they had the necessary training to enable them to fulfil this role.
- Staff confirmed to us that safeguarding vulnerable adults was included in their mandatory training. Hospital training records confirmed this.
- Processes were in place and followed to ensure the right patient received the correct radiological investigation at the right time. A senior radiographer reviewed all x-ray requests before patients were x-rayed. Consultant radiologists reviewed all GP referrals before x-ray.
- There was a cross checking system in outpatients that ensured the correct patient identity for the procedure. Reception staff checked patient details on arrival and took a photograph of the patient.The consultant or nurse, when calling through the patient, carried out a further check, by confirming their name. The clinical staff rechecked the patient details in the consultation room, to ensure the patient, their records and any electronic records related to the same patient.

Mandatory training

- Staff completed a number of mandatory training modules as part of their induction and updated them in line with the current training policy. Training included infection control, fire safety, conflict resolution, equality and diversity, information governance, children and adult safeguarding, manual handling and dementia awareness.
- The imaging and diagnostic team had a comprehensive induction checklist, and we saw evidence that competencies were checked for individual staff.
- Training was delivered through an online learning package or by face-to-face teaching and practical sessions. Staff reported they completed online learning and booked dates for the practical or face-to-face teaching sessions.
- The hospital did not provide data on what the target for compliance with mandatory training was. However, from the training records made available to us, almost all staff were up to date with the mandatory training. We saw evidence refresher training was booked for those who were due to for renewal.
- All training was monitored by the human resources team, who notified the team leads when training was due for renewal.
- No staff we spoke with reported any issues finding time to complete their mandatory training.

Assessing and responding to patient risk

- Patients at the hospital always had access to a registered medical officer (RMO), provided by an external contractor. RMOs were trained in advanced life support.They provided medical support to the outpatient staff if a patient became unwell. Patients

who became medically unwell in outpatients would be transferred to the inpatient ward or to the local acute NHS Trust in line with the emergency transfer policy. Staff reported this rarely happened.

- Emergency resuscitation equipment was available and was appropriately checked daily.
- Arrangements were in place for radiation risks within the comprehensive local rules. Local rules are the way diagnostics and imaging work in accordance with national guidance.
- In accordance with the ionising radiation (medical exposure) regulations (IR(ME)R 2000), policies and procedures were in place for staff to identify and manage risks. The policies had been reviewed and signed by staff to confirm these had been read and understood.
- Medical physicists advised on radiation safety conducted quality checks. The Regional Radiation Protection Service (RRPPS) provided this service under a service level agreement.
- There was clearly visible and appropriate radiation hazard signage outside the x-ray rooms for staff and patients.
- Imaging request cards included pregnancy checks for staff to complete to ensure women who may be pregnant informed radiographers before any exposure to radiation.

Nursing staffing

- The OPD used an acuity tool. This was a spread sheet that works out how many staff were needed for the different clinics. Every morning the lead nurse met with senior nursing staff to discuss what staffing was needed for the day. The acuity tool was also used to plan further ahead and to provide safe staffing levels when extra clinics were needed.
- Staff teams had daily meetings to share important updates, such as changes to planned clinics or staffing for the day.
- Staff told us they were willing to be flexible when needed, and told us they liked the work and patient safety was their priority.
- All outpatient areas, reported that they did not use any agency staff for the period April 2015 to March 2016. In the same period, there were no vacancies for nurses and care assistants in OPD.
- The rate of sickness for nurses working in outpatient departments was below the average of the 37 independent acute providers that we hold this type of data for except for in October and November 2015.
- The rate of sickness for outpatient health care assistants was below the average of the 35 independent acute providers that we hold this type of data for except in July 2015.
- The rate of outpatient nurse turnover was below the average of the 40 independent acute providers that we hold this type of data for.
- The rate of outpatient health care assistant turnover was below the average of the 38 independent acute providers that we hold this type of data for.

Medical staffing

- The hospital at the time of the inspection employed 103 medical staff working under rules or practising privileges. The hospital completed relevant checks against the Disclosure and Barring Service (DBS). The registered manager liaised appropriately with the GMC and local NHS trusts to check for any concerns and restrictions on practice for individual consultants.
- There was sufficient consultant staff to cover outpatient clinics, including Saturday clinics.
- Staff told us that medical staff were supportive and advice could be sought when needed.
- There was a registered medical officer RMO on duty 24 hours a day to provide medical support to the outpatient and imaging departments.

Major incident awareness and training

- Staff were aware of their roles and responsibilities during a major incident.
- The hospital had local and corporate business continuity plans with supporting action cards to use in events such as internet or electricity failure. The business continuity plans were also available electronically.

Good

Outpatients and diagnostic imaging

- We saw evidence that the business continuity plan was annually reviewed.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

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

- Patients care and treatment was planned and delivered in line with current evidence based guidance, best practice and legislation. Information about patient's care and treatment, and their outcomes, was routinely collected and monitored.
- There was evidence of local and national audits, including clinical audits and other monitoring activities such as reviews of services. However, WHO checklist audits had not been completed in the radiology department. Staff were qualified and had the appropriate skills to carry out their roles effectively, and in line with best practice.
- Staff were supported to deliver effective care and treatment, through meaningful and timely supervision and appraisal.
- Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005.

Evidence-based care and treatment

- Staff in in all outpatient areas reported they followed national or local guidelines and standards to ensure patients received effective and safe care.
- Radiation Exposure/diagnostic reference levels were audited regularly and evidence of these were seen during inspection.
- Clinical audits were undertaken in diagnostic imaging.An audit plan and the results of these were observed during inspection. These included audits in areas such as; clinical records, pre- assessment care, physiotherapy records, Ionising radiation, optical radiation, hand hygiene and infection control & prevention.
- However, we found although the WHO checklist was completed by the radiology department for patients, regular audits on this process were not always being completed.
- IR(ME)R audits were undertaken in line with regulatory responsibility,copies of these audits, outcomes, actions and results were seen during our inspection.IR(ME)R incidents were all within normal ranges. The hospital was not an outlier for under or over reporting of IR(ME)R incidents.
- In the diagnostic imaging department, there was good evidence that compliance with national guidelines was audited including audits against radiation exposure.
- All radiology reports were checked and verified by a radiologist, before the report was sent to the referrer.

Pain relief

- In the outpatient department, staff discussed options for pain relief with the patient, during their consultation before any procedure was performed. Many procedures could be performed with the use of local anaesthetic, enabling the patient to go home the same day. Patients were given written advice on any pain relief medications they may need to use at home, during their recovery from their outpatient procedure.
- Patient records evidenced pain relief was discussed and local anaesthesia was used for minor procedures.

Patient outcomes

- All radiology reports were audited for compliance with the reporting times. A designated staff member oversaw this process, and discussed the audit results with the radiologists. This ensured that a system was in place to prevent unverified reports causing delay to patient care.

Competent staff

- Patients told us that they felt staff were appropriately trained and competent to provide the care they needed. Staff confirmed they were well supported to maintain and further develop their professional skills and experience.

Good

Outpatients and diagnostic imaging

- In the period January 2016 to December 2016, 95% of outpatient nursing staff had received an appraisal. In the same period, 95% healthcare assistants had received an appraisal.All radiographers and radiography department assistants had received an appraisal.
- Practicing privileges is authority granted to a physician by a hospital governing board to allow them to provide patient care within that hospital. There were appropriate systems in place to ensure that all consultants' practising privileges were kept up-to-date. Evidence of this was seen during the inspection.

Multidisciplinary working

- From the care we observed, there was effective team working, with strong working relationships between all staff groups.
- If there were unexpected findings following a radiology imaging, the radiologists contacted the referring clinician and the radiographers followed up on the results to ensure if any further action was needed it was completed.

Seven-day services

- The majority of outpatient clinics were held Monday to Friday, with clinics running from 8:00am to 8.00pm Monday to Friday. Clinics were also held on Saturdays between 8am and 4pm. Patients we spoke to reported good access to appointments and at times which suited their needs.
- In diagnostic imaging, scans, x-rays and ultrasounds were available between 8am and 8pm Monday to Friday. During the weekend and overnight, radiographers were on call.

Access to information

- Staff we spoke with reported timely access to blood test results and diagnostic imaging.Results were available for the next appointment or for certain clinics, during that visit, which enabled prompt discussion with the patient on the findings and treatment plan.
- X-rays were available electronically for consultants to view in the clinic.
- There were appropriate systems in place to ensure safe transfer and accessibility of patient records if a patient needed to be transferred to another provider for their treatment. Medical staff we spoke with confirmed the transfer methods used and understood the required security aspects of data transfer.
- GP referral letters would also be available for private patients, unless self-referring. In each of the outpatient consulting rooms there was secure access to the hospital's digital imaging records, NHS imaging reports, as well as pathology reports.
- Clinical guidelines and procedures could be found by staff on the hospital intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Information about the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards was covered in the staff mandatory safeguarding training. Staff demonstrated good understanding about their role with regard to the Mental Capacity Act. The consent process for patients was well-structured, with written information and verbal explanation provided before consent for a procedure was sought.
- Verbal consent was given for most general x-ray procedures and OPD procedures. Some consultants sought written consent from patients for some procedures.

Are outpatients and diagnostic imaging services caring?

Good

By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

We rated 'caring' as good because:

- Feedback from patients and those close to them was positive. Patients told us they were treated with dignity, respect and kindness.
- Patient's privacy and confidentiality was respected. Staff demonstrated they were passionate about caring for patients and clearly put the patient's needs first, including their emotional needs.

Good

Outpatients and diagnostic imaging

Compassionate care

- Patients told us they were treated with privacy, dignity and respect and they felt staff cared for them.
- All the patients we spoke with were positive about the care and treatment they had received. We received comments such as; "Staff are caring", "The staff are thoughtful and understanding", and "The consultant and nurses are very considerate". There were no negative comments from any patients within outpatients and diagnostic imaging services.
- Throughout the inspection, we saw staff speaking in a calm and friendly way to patients. Patients told us staff were helpful and supportive.
- Information on how to access a chaperone was also available on the hospital website. Signs offering patients a chaperone were clearly displayed in waiting areas and clinical rooms.
- The hospital took part in the Friends and Family Test (FFT). There was no breakdown of the figures therefore it was not possible to identify the significance of these figures with regards to outpatients. For the reporting period October 2015 to March 2016 the hospital 98% of patients said they would recommend the hospital to their friends and families.
- The FFT survey response rates were variable, being above the England average in October, November 2015 and February 2016 to below the average in December 2015, January 2016 and March 2016.

Understanding and involvement of patients and those close to them

- Patients told us they had been provided with the relevant information, both verbal and written, to make informed decisions about their care and treatment. There had been sufficient time at their appointment for them to discuss any concerns they had.
- During our inspection, we saw there was a wide range of health promotion literature in waiting areas. This included leaflets on; orthopaedics, breast surgery, general surgery, physiotherapy and rheumatology.
- We saw patients' families, or carers were welcome to accompany them into their consultation providing the opportunity for a second person to hear what the doctor or nurses told the patient and clarify issues later if needed.

Emotional support

- Patients commented that they had been well supported emotionally by staff, particularly if they have received upsetting or difficult news at their appointment.
- Staff told us they spoke with patients who were emotionally distressed, in a private area. For example, one staff member told us they had provided support to a patient who had received upsetting news.
- During our conversations with staff it was clear they were passionate about caring for patients and put the patient's needs first.

Are outpatients and diagnostic imaging services responsive?

Good

By responsive, we mean that services are organised so they meet people's needs.

We rated responsive as good because:

- Services were planned and delivered in way which met the needs of the local population. Patients told us that there was good access to appointments and at times which suited their needs.
- Waiting times, delays, and cancellations were minimal and managed appropriately. Facilities and premises were appropriate for the services being delivered.
- There was openness and transparency in how complaints were dealt with.

Service planning and delivery to meet the needs of local people

- Services were planned around the needs and demands of patients. OPD clinics were arranged in line with the demand for each speciality. If consulting space was available, consultants could arrange unscheduled appointments to meet patient needs.

Good

Outpatients and diagnostic imaging

- Clinics were held on Monday to Friday, 8am to 8pm, with occasional outpatient clinics held at weekends to meet patient needs.
- There were waiting areas for OPD, diagnostic imaging and the physiotherapy departments; a range of different style chairs meant patients could chose a chair that was comfortable for them while waiting.
- The hospital was a provider of Choose and Book which is an E-Booking software application for the NHS in England which allows patients needing an outpatient appointment or surgical procedure to choose which hospital they are referred to by their GP, and to book a convenient date and time for their appointment.
- The hospital had free Wi-Fi for patients to use. This was valued by some of the patients we spoke with.

Access and flow

- Patient's appointments were arranged through the consultant's individual secretaries and with the outpatient reception team.
- NHS patients that used Choose & Book, and were subject to the NHS waiting time criteria, this was managed by the hospital's own administration team.
- The hospital met the target of 92% of incomplete pathway patients beginning treatment within 18 weeks of referral for each month for the reporting period April 2015 to March 2016. Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month.
- The hospital did not meet the target of 95% of non-admitted patients beginning their treatment within 18 weeks of referral for the reporting period April 2015 to May 2015. However, the hospital consistently met this target during the period of June 2015 to March 2016. Although these targets were abolished by the NHS, the service continued to monitor its performance against these targets.
- The hospital had very low 'Did not attend' (DNA) rates. All patients who missed their appointment were followed up and audited. Subsequently, the referrer was notified of the non-attendance.

Meeting people's individual needs

- Patient's individual needs and preferences were central to the planning and delivery of tailored services. For example, the Circle Kitchen team provided a two week home food delivery service. The Chef and his team personally delivered lunch, an afternoon snack and dinner to the patient's home on a daily basis. The food was freshly made and patients could choose from the set menu or place an order in line with their preference. This service was particularly beneficial for patients who had undertaken a procedure and were unable to cook for themselves.
- The Chef also provided tailor made nutritional juices for patients who were unable to swallow solid food. All meals were delivered with detailed instructions on how the meal was cooked, ingredients used, reheating and storing instructions; allergy labelling and each meal had been calorie-counted.
- This service had been running since January 2015, and between three to four patients each month had taken up this service. Approximately 80 patients had used this this service, in the last 18 months. We saw evidence patient's had fed back this service had made an impact on their health and well-being whilst recovering from treatment.
- Staff recognised the need for supporting people with complex needs, but there was minimal evidence that the needs and wishes of patients with learning disability or patients who lacked capacity were understood and taken into account.
- All staff had undertaken dementia awareness training, as part of the mandatory training,
- Information on specific procedures was provided by consultants at the hospital and shared during 'patient hours' learning sessions for staff. General information on coming into the hospital was also sent out to patients prior to admission.
- All written information and signage, including pre-appointment information was provided in English only. There was telephone interpreting service provided by language line, and staff we spoke with were aware of this and knew how to access this service if required.

Good

Outpatients and diagnostic imaging

- We noted in the Diagnostic Imaging waiting area there was a 'Pregnancy Safety Poster' displayed in different languages. This was also available to be given to patients in different languages, including Chinese, Urdu and Hindi.
- We found patients did not have access to a designated multi-faith room; although, all patients had their own rooms and could use this space to practice their faith should they wish to. This was supported by some patients we spoke with, who told us they had used their own room to offer religious prayers.
- In diagnostic imaging, we found patient information leaflets were not available.
- Chaperones were available to patients and there was information clearly displayed in the waiting area about the services. Booking staff told us that they were usually booked in advance either via patient or GP request.
- There was ample seating in waiting areas. All consulting rooms and communal spaces were accessible to patients.
- Space was restricted in the imaging and diagnostic department. Although staff told us this had not presented as an issue or risk yet, there had been no consideration given to access by patients needing to attend on their bed that may require a scan before or following surgery. There was no standard operating procedure in place.
- There were complimentary refreshment facilities provided in the hospital waiting areas.

Learning from complaints and concerns

- Patient's comments and complaints were listened to and acted upon. Information on how to make a complaint was provided on the complaints leaflet, and on the hospitals website.
- Staff were aware of the complaints procedure. The hospital promoted the four Cs process (complaints, concerns, comments and compliments). We saw where the four Cs were reported quarterly as part of the hospital's 'quality quartet' scorecard. Staff told us the four Cs were also be discussed at the 'patient hour' meetings.
- We saw evidence complaints were discussed at morning huddles, team meetings and 'patient hours'. Complaint themes and key learning was reviewed at the Clinical Governance and Risk Management Committee and disseminated throughout the hospital. Each area had a 'you said, we did' board identifying changes that had been made as a result of feedback from complaints.
- In addition, all complaints, concerns, compliments and themes were discussed within the hospital leadership team monthly meetings, quarterly integrated governance committee meetings and within the monthly executive board meetings.
- Staff told us if someone had a concern or a complaint they would try and deal with the matter there and then. Failing that, they would provide the patient with a feedback card and escalate the issue to their manager. This was in accordance with the hospitals policy on handling complaints.
- Formal complaints were received by the governance team and were documented on the incident reporting system. Any complaint response letters were checked by both the governance team and the hospitals general manager to ensure the complaint had been dealt with effectively.
- Patients we spoke with were aware of the process to follow if they wished to make a complaint.
- None of the patients we spoke with had ever needed to make a complaint.

Are outpatients and diagnostic imaging services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovations and promotes an open and fair culture.

We rated well-led as good because:

- There was a clear statement of vision and values, which was driven by quality and safety. Staff knew and understood the vision, values and strategic goals.

Good

Outpatients and diagnostic imaging

- Quality of care was regularly discussed at board meetings, and in other relevant meetings below board level.
- There was an effective and comprehensive process in place to identify, understand and monitor and address current and future risks.
- There was a culture of collective responsibility between teams and services. Information and analysis was used proactively to identify opportunities to drive improvement in care.

Vision and strategy for this this core service

- Circle Reading had a clear statement of vision and values, driven by quality and safety. The strategy was to deliver the highest quality outcomes, the best patient care and to be patient's number one choice. To deliver this vision the hospital had devised a vision and strategy 8 point plan. This plan included: being caring and kind to patients, going the extra mile, planning care that is individualised to the patient's needs, demonstrating respect and honesty and regularly monitoring clinical outcomes.
- The hospitals vision and strategy 8 point plan was visible on area noticeboards. Staff we spoke with made reference to the 8 point plan.
- The hospital had their own 'credo'. This described their purpose, parameters and principles for healthcare provision. We saw where this was clearly visible throughout the areas we visited. Staff we spoke with were able to refer to the credo and explain how their role fitted in with it.
- All staff demonstrated a commitment to providing quality and compassionate care for patients in an effective and efficient manner.
- Vision and values were discussed and reviewed regularly during, hospital leadership team meetings, senior management team meetings, patient hour meetings and staff forums.

Governance, risk management and quality measurement for this core service

- All policies were approved at a local and corporate level. Staff had access to policies in hard copy and on intranet.
- Policies for radiological examination were written up as standard operating procedures.
- Local guidance information was on display in every x-ray room.

Leadership / culture of service

- Managers in the outpatient, diagnostic imaging and physiotherapy departments had clinical roles and were highly visible and accessible. Staff reported good support and guidance from their managers. Managers were passionate about their teams and caring for their patients.
- In outpatient department, the team leader was working with the hospital administration team to streamline the booking process to release administration time within the outpatient department.
- Staff told us their immediate managers had appropriate skills, qualifications and experience to be able to lead and run departments, and were supportive.

Public and staff engagement

- Patients were encouraged to leave feedback about their experience by the use of a patient satisfaction feedback card and for NHS patients by the Friends and Family Test.
- During our visit we saw there were a number of collection boxes for patients to return their completed feedback cards or they could be returned by post. Survey results were completed by departmental leads, and results communicated back to the teams for action and learning.
- In addition, patients were encouraged to complete a compassionate care audit, which covered all aspects of care during their visit. The 2015 outpatients compassionate care audit results showed: 82% of patients felt empowered during their visit at the hospital and 78% patients had felt safe. The results were collated and review by the department and presented at the clinical governance and risk committee.
- The hospital carried out annual staff survey, as part of the performance management process. Staff were asked questions such as, if their opinions at work were valued, they received support from their manager and they had adequate materials and equipment to do their job. The results were collated on scoring system, with 1

being poor and three being very good. The average score, for the overall hospital, from the results in 2016 was 2.6. We noted the outpatients and physiotherapy departments scored highly.

- Staff told us patient feedback was raised and discussed during the 'patient hour' meeting. Patient hour was a weekly meeting, where teams from different departments got together to review, progress, discuss and plan improvement initiatives.
- Staff told us that the organisation increasingly engaged them through innovation awards. There was a 'Partner Recognition Award' scheme in place, whereby the partners nominated another member of staff who they believed had gone the 'extra mile'. Each quarter three members of staff were recognised and awarded for their contribution. We saw evidence that staff in the OPD were recipients of this award.
- The service engaged and involved all staff and ensured that the voices of staff were heard and acted on. For example, a significant number of staff were involved in creating the vision and strategy 8 point plan. This allowed staff to contribute directly to the hospitals vision and strategy. One staff member reported that including staff members in this process showed the hospital cared about its staff and that they were receptive to their views and suggestions.
- A monthly Newsletter was produced by the leadership team, which outlined where the hospital was doing well and areas which needed improvement. In the June 2016 newsletter items included; a message from the general manager, HR update, participation of recent charity events and financial update.

Innovation, improvement and sustainability

- Most staff reported the hospital supported innovation with the executive team responsive to requests and suggestions for improvement.
- The General Manager held bi-monthly staff partner forums. This allowed staff partners to ask questions and hear the latest news and business developments.
- The pharmacy team had developed an improvement and sustainability plan. This included four key aspects: Improvement in patient experience, achieving optimal value of medicines, best clinical outcomes and better partner engagement.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Ensure that statutory notifications are reported to the care quality commission in a timely way.
- Ensure that the Duty of Candour process is fully completed after an incident involving patient harm.

Action the provider SHOULD take to improve

- Resuscitation equipment for use with children should be removed from trolleys or there is a risk of confusion about what equipment to use in an emergency.
- Checks of defibrillators should include a record of a shock test in case the unit should fail to record this.
- Fluid balance charts for patients, especially those having intravenous fluids should be accurately completed.
- Ensure that audit of the use of the WHO checklist in the Diagnostic Imaging department is completed.
- Ensure that staff are trained in Duty of Candour and the application of this duty is monitored.
- Ensure patient leaflets are available in the imaging and diagnostic department.
- Ensure the space in the Diagnostic Imaging department is reviewed for bed patients, and a standard operating procedure is in place.
- Staff need to have an understanding of female genital mutilation (FGM) and the statutory action they would need to take to protect these patients.