Shepton Mallet NHS Treatment Centre

Quality Report

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

Ratings

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

Overall summary

Shepton Mallet NHS Treatment Centre is operated by Care UK. The hospital has 34 beds. Facilites include four theatres, one daycase and endoscopy theatre, sterile services department, and outpatient and diagnostic facilities.

The hospital provides surgery, and outpatients and diagnostic imaging. We inspected the core services using our comprehensive inspection methodology. We carried out the announced part of the inspection on 11 to 13 October 2016 and an unannounced visit on 26 October 2016.

Summary of findings

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

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

We rated this hospital as outstanding overall.

We found areas of outstanding practice in both surgery and outpatients and diagnostic imaging:

- There were strong, comprehensive and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse.
- Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times.
- A proactive approach to anticipating and managing risks was embedded and was recognised as being the responsibility of all staff.
- Patients had excellent outcomes and their care and treatment was planned and delivered in line with evidence-based guidance, standards and best practice.
- An extensive audit programme allowed early identification of areas for improvement and action plans were put in place as a result of any non-compliance.
- The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care. Staff had the skills required to carry out their roles effectively and were proactively supported to maintain and develop their professional skills and experience.
- There was outstanding care provided to the patients. Patients were respected and valued as individuals and were empowered as partners in their care. Patients were highly satisfied with the care they received and we observed this in practice.
- Services were planned and delivered in a way that met the needs of the local population. Flexibility, choice and continuity of care were reflected in both services.
- The hospital had robust policies and processes in place to effectively investigate, monitor and evaluate patient's complaints.
- Managers and staff were extremely proud of the organisation and the contribution they made to the healthcare of local people. Patient care was at the centre of everything they did.
- All departments had developed detailed objectives which outlined the quality and business plans for the next year in line with the hospital's strategic objectives.
- There were comprehensive governance arrangements in place which allowed the hospital to work in line with best practice and deliver high quality care.
- Frontline staff and senior managers were passionate about providing a high quality service for patients with a continual drive to improve the delivery of care.
- There was excellent local leadership of the services. The senior management team had an inspiring shared purpose and were committed to the patients who used the services, and also to their staff and each other.

However, we also found areas of practice that required improvement:

- The store room in theatre required reorganising to ensure the efficient management of supplies.
- The average waiting time for patients attending their first outpatient appointment with a consultant required improvement. The average waiting time was 25 minutes and data showed 9% of patients had waited for longer than an hour.
- Staff in the outpatients department were not consistently aware of how to access information in different formats/languages, and did not follow best practice by using relatives to translate.

Professor Edward Baker

Deputy Chief Inspector of Hospitals (South West)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Outstanding** ☆	We rated this service as outstanding because: • There were clear processes in place to ensure the safety of patients. Incidents were reported and investigated acted upon with feedback and learning provided to staff. • All areas in theatre and on the ward were visibly clean to a high standard and staff demonstrated good infection control practice to reduce the risk of infection. • There were policies and procedures to be followed for the safe management of medicines. • Comprehensive risk assessments were carried out and regularly reviewed. • Nursing and surgical staffing were planned and reviewed regularly in line with best practice guidance to ensure patients received safe care and treatment. Staff were knowledgeable and experienced in their roles. • Treatment and care were effective and delivered in accordance with best practice and recognised national guidelines. • Patients were well supported with nutrition, hydration and pain relief. • Patients were at the centre of the service and the priority for staff. • Patients received excellent care from dedicated, caring and well trained staff who were skilled in working and communicating with patients. • Staff understood the individual needs of patients and designed and delivered services to meet them. Patients were kept involved with their care and staff ensured their full understanding. • Patients spoke highly of the approach and commitment of the staff who provided the service. Feedback from those who used the service had been exceptionally positive. Staff went above and beyond their usual duties to ensure patients received compassionate care. • There were clear lines of local management in place and structures for managing governance and measuring quality.

Summary of findings

- The leadership and culture of the service drove improvement and the delivery of high-quality individual care.
- All staff were committed to patients and to their colleagues. There were high levels of staff satisfaction with staff saying they were proud of the hospital as a place to work. They spoke highly of the culture and levels of engagement from managers.
- There was a good track record of lessons learnt and improvements when things went wrong. This was supported by staff working in an open and honest culture with a desire to get things right.
- Innovation, high performance and the high quality of care were encouraged and acknowledged.

Outpatients and diagnostic imaging

Outstanding ☆

- There were robust systems in place for incident reporting, investigation and learning lessons. Staff received feedback on incidents raised.
- All staff (100%) in outpatients, physiotherapy and diagnostic imaging had completed their mandatory training.
- Staff had knowledge and awareness of safeguarding and despite not seeing or treating children had been trained to level two in children's safeguarding.
- The departments were visibly clean and tidy. Patient satisfaction scores and feedback from patients during our inspection confirmed the high levels of cleanliness.
- Robust systems were in place to make sure equipment was calibrated and serviced in line with manufacturer's instructions so that it was safe to use.
- Procedures were in place for the safe storage, prescribing and administration of medicines.
- Every patient who attended the hospital had their medical notes readily accessible in paper and electronic form.
- Staff had a good understanding of what posed a risk to patients and plans were in place to mitigate that risk as much as possible.
- Staffing within outpatients, physiotherapy and diagnostic imaging was sufficient to meet the needs of their patients.
- The staff were well trained and had the knowledge and skills to do their job.

Summary of findings

- The patient satisfaction scores showed consistently high rates of patient satisfaction. All the patients we spoke with during our inspection were very complimentary about the hospital, the staff and their care and treatment.
- We observed staff communicating with patients in a way they could understand and in a friendly, respectful and caring manner.
- Staff were aware of the needs of their individual patients and did everything they could to make the patients stay as good as it could be.
- Leadership was effective, approachable and visible. Managers were proud of their teams and the staff we spoke with were proud to work at the hospital.

Summary of findings

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Outstanding ☆

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Services we looked at
Surgery; Outpatients and diagnostic imaging;

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Background to Shepton Mallet NHS Treatment Centre

Shepton Mallet NHS Treatment Centre is operated by Care UK.

The hospital is registered to provide the following regulated activities:

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

The hospital is located in a semi-rural area in Shepton Mallet, Somerset. The hospital is sited adjacent to an NHS community hospital and within a building leased from NHS Property Services. The hospital provides surgery and outpatients and diagnostic imaging services to NHS patients and primarily serves the communities of Somerset. A registered manager has been in post since 1 April 2008.

Surgery services provide non-urgent surgery for adults who meet strict eligibility criteria to include being over the age of 18 years. Services delivered include orthopaedics, general surgery, ophthalmology and endoscopy, ear, nose and throat (ENT), gynaecology, urology and fracture management.

There are four theatres with normal operating sessions from Monday to Friday between 7.30am and 4pm and optional sessions on Saturdays from 7.30am to 4pm. Theatre 1 is for ophthalmology with capacity for emergency ophthalmic procedures. Theatre 2 is for general surgery, gynaecology, ENT, urology, and minor (non-joint space) orthopaedic procedures; this theatre has capacity for emergency surgical procedures. Theatres 3 and 4 are laminar flow orthopaedic theatres for major joint replacements, upper limb hand and shoulder, foot and ankle, and other orthopaedic procedures; these theatres have the capacity for emergency orthopaedic procedures. Theatre 5 is for recovery,day care, and endoscopy; this is a dedicated area providing colonoscopy, gastroscopy, sigmoidoscopy, and cystoscopy. Normal operating sessions are on Monday to Friday from 7.30am to 4pm with optional operating sessions available on Saturdays from 7.30am to 4pm.

There are eight recovery bays and 10 admission / discharge bays. There are two laminar flow Central Sterile Supplies Department (CSSD) rooms through which all equipment trays are steralised .

The inpatient ward has 34 beds, which are in the format of two / three bedded rooms with en-suite facilities, personal bedside telephones,TVs and free access to Wi-Fi.

Patients access the service at Shepton Mallet NHS Treatment Centre through referral by their GP or acute NHS trust and if eligible are seen in the outpatient clinic before an appointment is arranged for surgery.

The hospital also provides outpatient, physiotherapy and diagnostic imaging services to patients referred for treatment. Referrals are accepted from GPs and via the choose and book patient choice system as long as they meet the criteria for referral. Children or young person under the age of 18 are not treated in the departments.

The outpatient department sees patients from all specialties available within the hospital such as ear, nose and throat (ENT), general surgery, orthopaedic surgery, urology, ophthalmology and gynaecology.

The physiotherapy service provides a service to both inpatients and outpatients. They do not take external referrals, but only see patients having treatment at the hospital.

The diagnostic imaging department provides plain X-rays, ultrasounds and MRI (Magnetic Resonance Imaging) scans to patients attending the hospital.

The hospital was inspected in December 2014 which found that the hospital was meeting all standards of quality and safety it was inspected against.

Summary of this inspection

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and three specialist advisors with expertise in surgery, diagnostic imaging and outpatients. The inspection team was overseen by Helen Rawlings, Inspection Manager.

Information about Shepton Mallet NHS Treatment Centre

The hospital is registered to provide the following regulated activities:

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

During the inspection, we visited the inpatient ward, day surgery unit, theatres, post anaesthetic recovery unit, central sterile services department, outpatient department, diagnostic imaging, and physiotherapy. We spoke with 46 members of staff including the senior management team, heads of department, nurses, doctors, operating department practitioners, health care assistants, catering staff and administration and reception staff. We held two drop-in sessions which were attended by 23 members of staff. We spoke with 22 patients and two relatives. We met with three members of the patient forum and obtained patient feedback through 10 comment cards. We observed care and reviewed 15 sets of patient records.

The hospital was inspected in November 2014 which found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity (July 2015 to June 2016):

- In the reporting period July 2015 to June 2016 there were 7,760 inpatient and day case episodes of care recorded at the hospital and 24,517 outpatient attendances at the hostpial. Of these 100% were NHS-funded.

Track record on safety;

- No never events were reported during the last 12 months. A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.
- There were 221 clinical incidents. Of these incidents 193 were categorised as no harm, 17 were categorised as low harm, one was categorised as moderate, none were categorised as severe and none were categorised as a death. The number of incidents by degree of harm did not match the total number of incidents. This had been attributed to the reporting of incidents that were not true incidents or where the clinical outcome had already been reported.
- There were 114 non-clinical incidents. These non-clinical incidents are all those which do not involve patient care such as equipment failures
- There were no incidences of healthcare-associated Methicillin-resistant Staphylococcus aureaus (MRSA)
- There were no incidences of healthcare-associated Methicillin-senstitive staphylococcus aureaus (MSSA)
- There were no incidences of healthcare-associated Clostridium difficile
- There were no incidences of healthcare-associated E-Coli
- There were 21 complaints

Services accredited by a national body:

- British Standards Institute (BSI) accredited Central Sterile Supplies Department (CSSD).
- Joint Advisory Group on GI endoscopy (JAGS) accreditation.
- International Organisation Standardisation (ISO) 9001 accreditation for a quality management system.

Services provided at the hospital under service level agreement:

Summary of this inspection

- Resident Medical Officer provision
- Occupational health
- Pathology and histology
- Emergency transfers
- Emergency ambulances
- Taxis
- Bus service
- Audiology service
- Facilities management
- Consultant Urologist
- Consultant Orthopaedic Surgeon
- Optometrist

The hospital manages two clinical services under sub-contracted arrangements:

- Medical termination of pregnancy at a community hospital
- Teledermatology service between GPs and consultant dermatologists

The hospital operates clinics at community hospitals for:

- Fracture review
- Outpatient consultations

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?

Outstanding 

We rated safe as outstanding because:

- There were systems in place for recording and learning lessons from incidents and staff told us they were encouraged to report incidents
- Harm free care was monitored using the safety thermometer and the hospital assessed patients and monitored pressure ulcers, falls, venous thromboembolism and catheter associated urinary tract infections.
- The ward and theatre departments were visibly clean and well organised. Staff adhered to infection prevention and control policies and protocols.
- Equipment appeared fit for purpose and was well maintained.
- Systems were in place for the safe storage and administration of medicines Records were complete, accurate, legible and up to date and reflected patient's individual needs.
- Staff were knowledgeable about the safeguarding processes and understood their responsibilities to report concerns.
- Mandatory training was monitored each month and most staff were compliant with their training.
- Surgical staff followed the World Health Organisation (WHO) safe surgery checklist.
- Processes were in place to respond to a deteriorating patient, there was a competent resuscitation team and staff had knowledge of emergency transfer procedures.
- Business continuity plans were in place in case of planned and unplanned events that could cause disruption to the normal running of the hospital.
- There were robust systems in place for incident reporting, investigation and learning lessons. Staff received feedback on incidents raised.
- All staff (100%) in outpatients, physiotherapy and diagnostic imaging had completed their mandatory training.
- Staff had knowledge and awareness of safeguarding and despite not seeing or treating children had been trained to level two in children's safeguarding.
- The hospital had a visitor's policy in place to know who was on site and what they were doing in order to protect patients.
- The departments we visited were visibly clean and tidy. Patient satisfaction scores and feedback from patients during our inspection confirmed the high levels of cleanliness.

Summary of this inspection

- Robust systems where in place to make sure equipment was calibrated and serviced in line with manufacturer's instructions so that it was safe to use.
- Procedures were in place for the safe storage, prescribing and administration of medicines.
- Every patient who attended the hospital had their medical notes readily accessible in paper and electronic form.
- The hospital and staff had an excellent understanding of what posed a risk to patients, and plans were in place to mitigate that risk as much as possible.
- Staffing within outpatients, physiotherapy and diagnostic imaging was sufficient to meet the needs of their patients.

However the following area required improvement:

- The theatre equipment store was not efficiently maintained and required reorganising.

Are services effective?

Outstanding ☆

We rated effective as outstanding because:

- Patients had good outcomes as they received effective care and treatment to meet their needs.
- Treatment by all staff was delivered in accordance with best practice and recognised national guidelines.
- Patients were at the centre of the service and the priority for staff. High quality performance and care were encouraged and acknowledged and all staff were engaged in monitoring and improving outcomes for patients.
- Staff skills and competence were examined and staff were supported to obtain new skills and share best practice.
- There was a comprehensive learning management system in place that was fully auditable and up to date.
- Multidisciplinary team working was excellent throughout the surgery service.
- Information was readily available to staff to deliver effective care and treatment, and appropriate communication and relationships were maintained externally.
- Patients' pain relief was effectively reviewed and managed.
- The nutritional and hydration needs of patients was assessed and met.

The effectiveness of outpatients and diagnostic services was not rated due to insufficient data being available to rate these departments' effectiveness nationally.

We found:

Summary of this inspection

- The hospital had provided a teledermatology service since 2014 and had reduced the number of referrals to acute hospital dermatology services.
- The physiotherapy team had established a falls programme which had seen a reduction in the number of falls suffered by patients following joint replacement surgery.
- The physiotherapy tracked their patients and were able to demonstrate improved outcomes because treatment could be tailored to suit that individual patient.
- The staff were well trained and had the knowledge and skills to do their job.

Are services caring?

Outstanding 

We rated caring as outstanding because:

- Patients were treated as individuals. Feedback from patients and their relatives had been exceptionally positive. They praised the way the staff really understood their needs.
- Patients said staff were caring and compassionate, treated them with dignity and respect, and made them feel safe. Staff went above and beyond their usual duties to ensure patients experienced high quality care.
- Staff were skilled to be able to communicate well with patients to reduce their anxieties and keep them informed of what was happening and involved in their care. They were able to ask questions and raise anxieties and concerns and receive answers and information they could understand
- We observed outstanding care. and observed staff treating patients with kindness and warmth.
- The theatres and ward were busy and professionally run, but staff always had time to provide individualised care.
- All staff including clinical staff and supporting teams were highly motivated to provide person centred care which was dignified, kind, compassionate, respectful and professional.
- The patient satisfaction scores showed consistently high rates of patient satisfaction.
- Staff were aware of the needs of their individual patients and did everything they could to make the patients stay as good as it could be.

Are services responsive?

Outstanding 

We rated responsive as outstanding because:

- The service was committed to delivering care in a manner that recognised, respected, and responded to the diversity of the people to whom they provided clinical services.

Summary of this inspection

- Services were tailored to meet the needs of individual patients and were delivered in a flexible way.
- The outpatients department ran 'one-stop' clinics for patients to see the consultant and then have the necessary tests if deemed suitable for surgery Individual patient needs were identified at their pre-operative assessment and where possible staff accommodated patient needs during their time in hospital.
- A computer application (pocket physio) for use on mobile phones had been developed with extensive clinical input from members of the physiotherapy department.
- The hospital achieved all its waiting time targets.
- There were good facilities for patients.
- Complaints were handled appropriately and learning from complaints was shared.
- There were no barriers for those making a complaint. Staff actively invited feedback from patients and were very open to learning and improvement. There were, however, few complaints made to the unit. Those that had been made were fully investigated and responded to with compassion.

However the following areas required improvement:

- The average waiting time for patients attending their first outpatient appointment with a consultant required improvement. The average waiting time was 25 minutes and data showed 9% of patients had waited for longer than an hour.
- Staff were not consistently aware of how to access information in different formats/languages, and did not follow best practice by using relatives to translate.

Are services well-led?

Outstanding ☆

We rated well-led as outstanding because:

- The leadership, management and governance of the services was outstanding and assured the delivery of high-quality person-centred care. The clinical managers were committed to the patients in their care, their staff and the service.
- There were clear departmental objectives and staff were able to repeat this and understood their responsibilities to achieve the objectives for the service.
- There was a strong local leadership, the senior management team were visible, approachable and supportive, and motivated and inspired all staff.
- Frontline staff and managers were passionate about providing a high quality service for patients with a continual drive to improve the delivery of care.

Summary of this inspection

- The culture was one of openness and transparency. A culture where staff could learn from mistakes and not be blamed for them.
- There was a high level of staff satisfaction with staff saying they were proud of the centre as a place to work. They showed commitment to the patients, their responsibilities and to one another. All staff were treated with respect and their views and opinions heard and valued.
- Patients were able to give their feedback on the services they received; this was recorded and acted upon where necessary.
- Managers understood the key risk management issues and risk registers were maintained and reviewed regularly
- An extensive audit programme was used to monitor the hospital's performance and quality of care, clear action plans were put in place if non-compliance was identified and learning was shared.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Outstanding ☆

Surgery

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

Are surgery services safe?

Outstanding ☆

We rated safe as outstanding because:.

Incidents

- No never events were reported during the last 12 months. A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.
- There were systems to make sure incidents were reported and investigated appropriately. Staff were open, transparent and honest about reporting incidents and said they would have no hesitation in reporting incidents, and were clear about how they would report them. All staff received training on incident reporting and risk management. The policy described the root cause analysis investigation process and the roles and responsibilities of staff involved in the process.
- All staff reported incidents directly onto an electronic reporting system. Once reported, incidents were reviewed by the appropriate clinical manager and where necessary investigated. Staff said they were able to get feedback on incidents they reported. Feedback was given via email and cascaded to staff through team meetings.
- There were a total of 50 clinical incidents and 43 non-clinical incidents in the reporting period July 2015 to June 2016. Non-clinical incidents are all those incidents which did not involve patient care and included equipment failures. There had been one serious clinical incident.
- All incidents were reviewed and discussed at the monthly quality governance assurance meetings.
- Bi-monthly mortality and morbidity meetings were held at which adverse incidents, and near misses, were discussed in an open and engaged manner. Between July 2015 and June 2016 there were no inpatient deaths.
- Staff provided an example of how learning or changes had been following an error in the recording of the temperature of a blood fridge. As a result of this incident processes were reviewed to ensure clear guidelines were in place for the future.
- A further example of learning from an incident related to failure of the blood fridge on the ward following a strike of lightening to the building where emergency guidelines were reviewed.
- Learning from incidents was shared corporately from other Care UK providers.

Duty of Candour

- Staff demonstrated an understanding of Duty of Candour responsibilities. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong.
- To ensure compliance, there was a Duty of Candour corporate policy to guide staff. Theatre and ward staff had 100% compliance with this training module. Duty of candour had been incorporated into the electronic reporting system. We saw examples of incidents where the process was triggered and the resulting actions taken including telephone and written contact with the patient.

Safety thermometer

- The service participated in the national safety thermometer programme and achieved consistently positive results. Data on patient harm was reported each month to the NHS Health and Social Care Information Centre. This was nationally collected data providing a snapshot of patient harms on one specific day each month. It covered incidences of healthcare-associated (new) pressure ulcers, patient falls with harm, urinary tract infections, venous thromboembolisms (VTE), and pulmonary embolism (PE). There were five incidents of hospital acquired VTE and PE in the reporting period July 2015 to June 2016. In the last 12 months the percentage of patients risk-assessed for VTE was 99.5%.
- All patients on admission and within 24 hours of admission received an assessment of VTE and bleeding risk, in line with the National Institute for Health and Care Excellence (NICE) quality standard. VTE was monitored twice daily throughout a patient's inpatient stay and audits were completed monthly to which included a VTE patient pathway audit.
- The use of catheters was risk assessed and urinary tract infections were monitored.

Cleanliness, infection control and hygiene

- Systems were in place to monitor and prevent the spread of infection within the hospital.
- We saw the infection, prevention & control action plan for 2016 where key actions included the monitoring of hand hygiene in each department, reviewing the training needs of link nurses, introducing Chlorhexidine pre-op skin wash in line with new policy, reviewing the management of potential urinary tract infections at pre-assessment, and developing a universal approach to suspected wound infection.
- An infection control lead was present in the hospital and infection control link nurses were within each department. We also saw the minutes of the bi-monthly infection prevention control link practitioner meeting where agenda items included audits, hand hygiene and sharps injury.
- All surgical and ward areas appeared visibly clean. Equipment appeared clean and we saw green 'I am clean' labels placed on trolleys and equipment that had been cleaned and were ready for use. We observed staff clean equipment and apply these labels. Curtains were regularly changed every six months and labels had been placed on curtains with the date they were to be changed.
- Bed spaces were visibly clean in both the easy and hard to reach areas. Bed linen was in good condition, visibly clean and free from stains or damage to the material. Areas had a dedicated team of cleaners who ensured the areas were clean and tidy. Cleaning checklists were in place and complete to ensure the ward and theatre departments were cleaned regularly.
- When speaking to patients everyone commented on the cleanliness of the hospital. With one patient remarking that "dust doesn't stand a chance here because they're always cleaning."
- In the theatre department the flow of sterile and contaminated equipment was appropriately segregated. The hospital's central sterile services department had a British Standards Institution (BSI) certificate of registration for the provision of their service of decontamination and moist heat sterilisation of surgical instrument sets. An unannounced BSI inspection found no outstanding and no new non-conformities, confirming compliance with international organisation for standardisation.
- Disposable items of equipment were discarded appropriately, either in clinical waste bins or sharp instrument containers. Nursing staff said these were emptied regularly and none of the bins or containers we saw were unacceptably full. Clinical waste was collected three times per week.
- We observed all clinical staff, including doctors, nursing staff and therapists washing their hands and using anti-bacterial gel in line with infection prevention and control guidelines. Non-clinical staff including reception and administrative staff and cleaning staff were also observed to be following the guidelines. Alcohol hand gel was readily available at entrances to the ward, day surgery unit and theatre areas and on entrance to patient rooms and at bed spaces. All staff, as required, were bare below the elbow when working on the ward and in theatre.
- There were no healthcare-associated infections or incidences such as methicillin resistant Staphylococcus aureus (MRSA), Clostridium difficile (C. diff), Methicillin-sensitive Staphylococcus aureus (MSSA) or E.Coli in the past 12 months. There were no hip surgical site infections (SSIs), however, there were two SSIs

resulting from knee operations giving a rate of 0.5 per 100 surgeries. For the two surgical site infections root cause analysis was undertaken and recommendations made for lessons to be learnt. The recommendations were communicated internally through reporting to management and disseminating via departmental, clinical governance and heads of department meetings, and were documented in the patient's notes. Externally the patients' GPs and Public Health England were informed. Surgical site infections were monitored by the infection control lead.

- Patients risk of colonisation and likely outcome prior to admission were assessed and screening was undertaken where patients met the criteria. For example, those undergoing procedures resulting in an orthopaedic long term prosthetic implant such as knee or hip replacement, or previously known to be MRSA positive.
- There was an outbreak of Norovirus reported in April 2016; the first outbreak in over ten years since the centre opened. The report detailed how the outbreak was managed and patients isolated once symptoms were recognised in line with the outbreak management of gastroenteritis protocol. All staff were reminded about the importance of washing hands rather than using alcohol gel during the outbreak and posters were placed at strategic points throughout the hospital. Lessons learned were identified and the protocol was revised with an action plan to devise a local flow diagram to identify local processes, and to display public information more prominently at the commencement of the next norovirus season.
- The patient led assessment of the care environment (PLACE) scores from February 2016 to June 2016 showed the hospital scored 100% for cleanliness and 96% for site maintenance.
- Personal protective equipment (PPE) was available for staff to use such as full gown and mask protection, plastic disposable aprons and gloves.

Environment and equipment

- Facilities and premises within surgery were designed in a way that kept people safe. Systems were in place to ensure the safe use, maintenance and replacement of equipment. There was a corporate procurement programme, purchasing items from accredited and approved sources and this was supported by a facilities management programme of regular planned preventative maintenance and portable appliance testing (PAT). The layout of the ward and theatres created an efficient flow. All areas were in good decorative order and well maintained and all equipment observed appeared fit for purpose.
- Windows had restricted opening to prevent the risk of falling.
- Fire exits were clearly marked with no obstructions and fire extinguishers and fire blankets were in date of their annual checks.
- The anaesthetic room was an appropriate size to undertake safe anaesthesia, with room to manage a cardiac arrest or other unexpected event. The layout ensured easy to find products with minimal stock stored in cupboards and drawers.
- Daily checks of the bed spaces on the main ward were completed and we saw records of this. Checks included suction, oxygen, nasal prongs, call bells, bed and brakes and gel dispensers.
- There was safe provision of resuscitation equipment in all areas. The trolleys carrying the equipment and medicines had been checked daily for completeness and full working order and this was documented. Checks on equipment were well maintained and the diary of defibrillator printouts confirmed the checks were within defined parameters.
- We saw a range of equipment was readily available and staff said they had access to the equipment they needed for the care and treatment of patients.
- The hospital provided a range of equipment to meet patients' post-operative needs. This included a toilet seat rise, walking frames, crutches, wheelchairs, leg lifters, long-handled shoe horn, grabber to pick up items and appropriate supports.
- There was a physiotherapy assessment area adjacent to the ward and included all equipment necessary to assess patients' suitability for surgery and discharge.
- Regular stock takes were completed and included checking of expiry dates and ensuring appropriate stock rotation. We reviewed a random sample of equipment in the store room and across the theatres, ward and day case departments and all were in date.
- Specialised equipment was ordered in advance in line with the standard operating protocol for ordering special equipment to which consultants, clinical staff and administration staff complied.
- The intravenous fluid store cupboard was well organised and potassium fluids were kept separately in

a secure cupboard. However, the theatre equipment store was not efficiently maintained. Although there was labelling and visual management of stock there was no obvious list of contents or clear organisation. Staff said a dedicated person was needed to sort it out and they did not have the resources to manage the store. This had already been raised with the senior management team. An action plan was not currently in place to address this issue.

- The difficult airway trolley was available in theatre and was well stocked and checked daily.
- Oxygen cylinders were seen to be present at an appropriate fill level and in date. Additional small cylinders were available for patient transfer or if a patient needed to go to the bathroom.
- The intersurgical anaesthetic machine daily check log book had been completed.
- Medical gases were checked daily. There was a three monthly air quality check and planned preventative maintenance. A contingency plan was in place for failed piped gases.
- Processes were in place to ensure that there was availability of a range of prosthetics held in stock. This ensured appropriate choice of prosthetics and avoided the cancellation of procedures due to lack of availability.
- Stock numbers were maintained against agreed stock levels and agreed replacement processes with manufacturers were in place to ensure prompt replacement. Orthopaedic and ophthalmic prosthetic stocks were kept within the orthopaedic and ophthalmology theatres, in appropriately secured containers, readily available intra-operatively.
- There was a procedure for ordering loan equipment and specific prosthetics; and specific lenses. The orthopaedic team liaised with company representatives who provided education and training when required.
- There was a British Standards Institute (BSI) accredited Central Sterile Supplies Department (CSSD) through which all equipment trays were centralised. The CSSD maintained a quality management system for the management of the decontamination of surgical instruments and trays. Each tray contained an instrument list, each of which was subject to audit upon leaving and arriving back within the department. Audit results were discussed with the theatre manager monthly and disseminated at monthly governance meetings.
- Swabs were added after opening the surgical packs and were subject to local swab and instrument count processes. All swabs contained radio opaque markers when used in invasive procedures.
- There were efficient clinical waste arrangements in place. Sharps bins were observed to be temporarily closed when not in use; they were not overfilled and were labelled and dated.
- There was no need for bariatric equipment as patients who had a body mass index (BMI) over 45 did not meet the criteria for surgery. All standard moving and handling equipment was able to meet patient needs.
- The hospital had adequate security systems in place to protect patients and staff. This included CCTV and swipe card access to locked areas. Staff said they felt safe in their working environment.
- Staff said there were space restrictions in the current configuration of the building although they worked around space problems and were creative in finding solutions.

Medicines

- Staff had access to the hospital's medicines management policy. This defined the policies and procedures to be followed for the management of medicines and included obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines. Staff were knowledgeable about the policy and told us how medicines were ordered, recorded and stored.
- We looked at the medicines storage audits, incidents and complaints, storage security, medicines records, and supply and waste-disposal processes. Medicines, including those requiring cool storage, were stored safely and kept within recommended temperature range. During our inspection we found all medicines stored securely, and were only accessible to authorised staff. All drug trolleys and cupboards were locked and the stocks well organised.
- The hospital had its own pharmacy on site that was able to dispense medicines both to the ward and to patients using internal prescription forms. The pharmacy was licenced by the Home Office for the handling, storage and administration of controlled drugs.
- The pharmacy was open on Monday to Friday from 9am to 5pm. Prescriptions and medicines were distributed in

a planned and timely manner during working hours. The pharmacy service had the capacity to adjust to the workload and types of procedures, so that medications could be ordered in a timely manner.

- An out of hours service was also in place to ensure that in an emergency, theatre staff or doctors could get access if needed.
- Pharmacists were responsible for clinically checking all prescriptions and recorded every intervention and amendment in a data sheet which was presented monthly to the medical director and to the clinical governance team. The pharmacist on duty also did a daily ward round to see all inpatients and reconcile their medications as per Royal Pharmaceutical Society hospital standards as soon as they arrived at the hospital or immediately after their procedure. This activity was also recorded in a weekly data sheet where the pharmacist recorded all aspects of medicine management and optimisation.
- The lead pharmacist was responsible for training and advising all clinical staff on the protocols and on the guidance in place within the group as well as at a local level. The lead pharmacist undertook medicines management training face-to-face, specific to the needs of each department.
- Operating surgeons or the on call surgeon, were responsible for antibiotic prescribing in case of infection or suspected infection. The antimicrobial stewardship (AMS) committee provided oversight and input into the development, implementation and ongoing review of the antimicrobial stewardship programme. A systematic approach reduced inappropriate antimicrobial use and adverse consequences of use in order to improve patient outcomes. Data was audited each month with feedback provided to prescribing clinicians and via clinical governance for shared learning and review.
- We observed medicines in theatre and ward departments to be in date.
- Medicines were stored appropriately in drug fridges and temperature checks were completed and recorded daily and were within correct parameters.
- Blood fridges were located in theatre and on the ward and temperatures were checked and recorded daily.
- To take home (TTO) medicines were regularly monitored with daily checks and we observed the register for TTO medicines completed.
- There were appropriate systems in place to make sure patients received their medicines in a timely way, both throughout their time at hospital and at discharge.
- Records of administration were completed clearly and correctly.
- We reviewed controlled drug records and real time recording of drug usage was evident. The responsible person and witness completed the controlled drugs book and maintained stock entries according to legal requirements and medicine management standards. The hospital had been issued with a controlled drugs licence.
- We reviewed five prescription charts for patients on the ward. Medicine records were completed with allergies and doses; they were signed and dated with time for administration of medicines documented.
- Nurses used patient prescription charts during their nursing handover to discuss medication in detail which included any medication prescribed, administered through the day or required through the night shift. The nurses emphasised any patient allergies.
- In the discharge pack patients were provided with information about their medicines to take home, highlighting medication names, information about what the medicine was for and the frequency of taking the medication.
- Medication incidents were reported via the electronic reporting system. All medication incident investigations had pharmacy input.

Records

- Medical notes for inpatients were stored securely to ensure confidentiality. Patient records demonstrated a multidisciplinary collaborative approach to patient care and were well maintained.
- The hospital used an electronic patient record system in addition to the paper records. We reviewed five sets of notes. All records were complete, accurate, legible and up-to-date. All clinical staff completed informative evaluation notes and reflected the needs of patients. We checked a range of information including neurological observation, fluid prescription and balance charts, observation chart for the national early warning score (NEWS), malnutrition universal screening tool (MUST) food chart and care plan, anaesthetic record and medication and prescription administration record. Information was clear and concise and care plans were

up-to-date. All early warning scores were completed and accurately recorded to reflect the routine observations undertaken to determine where intervention might be required.

- Nursing staff completed regular risk assessments on the electronic patient record. Risk assessments included; venous thromboembolism, falls, manual handling, repositioning, and neurovascular observations. From a review of five electronic records these assessments were completed regularly, where appropriate in pre-operative assessment, at admission, in recovery, in the day surgery unit and throughout the patient's stay on the inpatient ward.
- The World Health Organisation five steps to safer surgery checklist was completed on all five electronic records reviewed. We observed in theatre, staff completing the checklist on the electronic patient record following the verbal check. There were also theatre briefing check lists for the beginning of every list including the staff present, confirmation of running order, any known patient complications and availability of equipment required. De-briefing checklists were completed at the end of the lists and covered what went well, what could have been improved, learning points and the multidisciplinary team satisfaction score with the theatre list.
- The electronic patient record included arrangements for discharge and a discharge checklist to include clinical activity, medication supplied and patient education. We reviewed copies of discharge summaries on the electronic patient record.
- Standard operating procedures (SOPs) outlined the processes that were followed for the management of health records. Processes for the creation, storage, tracking, access, disclosure and destruction of health records were in line with the requirements of the policy and were ratified locally through the integrated governance committee.
- The policy applied to all types of health records, regardless of the media on which they were held. These included patient health records, X-ray and imaging reports, output and images, photographs, slides, and other images, microform (i.e. microfiche/microfilm), audio and video tapes, cassettes, CD-ROM and DVD, computerised records and scanned records.
- Compliance to the policy was monitored through the completion of a health record audit which included patients' details, consent, observations on admission, surgical safety checklists, prescription charts, follow-up, clinical outcomes and discharge letter. Data from March to May 2016 showed consistently high percentages ranging from 80% to 98%. However, one score was lower at 70% as a result of paper documents missing from the patient record. An action plan was developed to address audit findings as part of the internal assurance process.

Safeguarding

- There were policies, systems and processes for safeguarding patients. The standard operating procedure clearly described the roles and responsibilities for staff in reporting concerns and contained a process algorithm and local contact numbers.
- Staff we spoke with were knowledgeable about the safeguarding policy and processes, and were clear about their responsibilities and described what actions they would take should they have safeguarding concerns about a patient.
- Staff were trained to the appropriate level relevant to their role and responsibilities. Records indicated that safeguarding training was up-to-date for all staff with compliance exceeding the 90% target. All staff who completed level two modules were required to complete three hours of local updates annually conducted by the safeguarding lead. This included pre-reading and face-to-face information sessions.
- There had been no safeguarding incidents from June 2015 to June 2016.
- There was a safeguarding lead for both adults and children. They had appropriate safeguarding level four training and attended local safeguarding meetings, and received specific clinical supervision from the Care UK safeguarding lead. They also delivered face to face mandatory training for safeguarding adults and children, PREVENT which covers the protection of children from the risk of radicalisation, mental capacity and deprivation of liberties and female genital mutilation (FGM). Staff said the quality of safeguarding training was good. At the time of our visit training records showed 95.8% compliance with safeguarding training. Whilst the treatment centre did not treat any child or young person under the age of 18, the hospital recognised that children would attend as visitors of other patients. Therefore, staff had received children's safeguarding training to level two.

- There was a link safeguarding nurse in every department.
- The safeguarding lead checked if there were any concerns raised ahead of patient admission and maintained a spreadsheet with details of concerns and outcomes recorded. Data was used to inform learning at staff meetings. We were told about an instance where safeguarding concerns had been raised about a patient's relative and the actions taken to support them.
- The hospital had a visitor's policy in place which was implemented following a national review into safeguarding. The policy highlighted the importance of knowing what visitors were in the hospital, what they were doing and who they were with. This meant that visitors did not have access to areas that they did not need to be in, or pose a risk to other patients.
- There was also a group visitors' agreement which ensured that when multiple visitors were on site they were managed appropriately and effectively. Information was required from organisations wishing to make use of the conference room facilities including the name of the organisation and responsible individual, start date and estimated visitor numbers per visit.
- Patient security was maintained on site only allowing access to patient treatment areas by swipe card, or accompanied according to the visitor policy. All visitors were signed in and out at the main reception. Car registrations were recorded and visitor badges were provided to all individuals and had be worn at all times.

Mandatory training

- A programme of mandatory training was provided to all staff which included key skill sets divided into the following categories: health safety and environment, information governance and data protection, safeguarding of adults and children, clinical governance, resuscitation, medication, equality, diversity and human rights.
- Mandatory training was available using a range of methods to maximise accessibility, including face-to-face sessions, e-learning and a mobile phone application. All e-learning could be accessed via a learning management system and could be accessed on site, from home or remotely. Face-to-face training events were accessed via a training events calendar. A booking form was sent to the line manager for approval. Where staff could not complete courses during the working day due to clinical continuity they were able to access training on laptops at home and were paid overtime to do so.
- Staff told us that mandatory training updates were delivered to meet their needs and that they were able to access training as they needed it. Most staff said they were up-to-date with their mandatory training or had dates booked to attend training in the near future. Data provided showed the current compliance rate, at September 2016 as 93% against a target of 90%. This meant that most staff remained up-to-date with their skills and knowledge to enable them to care for patients.
- Other courses available were displayed on the intranet such as project management, customer care, equality and diversity and team manager essentials. A number of staff told us they were completing NVQ courses in their own time. User guides and information were available via tabs on the system such as nurse revalidation and resus guidelines.
- Staff were required to take ownership of their own training and compliance. The system sent out two email prompts when training modules were due.
- An overview of training compliance was maintained which meant there was an accurate record of the status of courses completed. Emails were generated and sent to heads of department to advise them who needed to update and monthly reports were generated, and considered as part of governance statistics to monitor compliance.
- There were six site trainers who delivered face-to-face training on site. They were assigned roles on the system and new courses were added centrally, and a round robin email was sent across the organisation. Information about the system was disseminated from the corporate head of education and training.
- Staff were responsible for their own supervision and arranging appointments with their supervisor. Time was protected and an agreement was signed by the supervisee and supervisor and notes were maintained.

Assessing and responding to patient risk

- Patient risk assessments were completed and evaluated. There were clear processes to deal with patients where their medical condition was deteriorating.

- Risk assessments were used to keep patients safe and were in line with national guidance. Assessments included; venous thromboembolism, water flow, falls, manual handling, repositioning, visual phlebitis and neurovascular observations.
- The hospital had in place a referral criteria. Patients were excluded if they were under 18 years of age, had a high suspicion of cancer, were a clinical emergency, had poorly controlled co-morbidities, pregnant or with a body mass index more than 42 for general anaesthesia or more than 45 for local anaesthesia.
- General health assessments, investigative tests, current medication and known allergies were recorded to allow staff to assess and minimise risk of adverse surgical outcomes.
- Patient care was consultant led and consultants reviewed care and confirmed treatment daily. The resident medical officer was on site and out of hours, was available for nursing staff to contact. An on-call team of consultant anaesthetists and consultant surgeons were available to respond to patient risks, there was also a rota for an on-call theatre team.
- The National Early Warning System (NEWS) was used for patient observation in recovery and during their stay on the ward. This tool enabled the clinical risk of patients to be assessed for early detection of a deteriorating patient. NEWS was audited monthly.
- The World Health Organisation (WHO) five steps to safer surgery checklists were used in theatre. We saw WHO checklists were completed verbally and in full.
- We observed handovers where each patient was discussed in detail, to include the care they had received and the care they would need, highlighting any risk areas.
- Patients were provided with discharge information to include managing their surgical wounds, thrombosis, and reducing the risk of developing blood clots. This provided patients with awareness of risk areas.
- Patients were provided with a hotline number to contact following discharge if they had any concerns or needed advice. They were also telephoned by nursing staff the day following discharge to check on their condition.
- There were local safety standards for invasive procedures (LocSSIPs) to set out the key steps necessary to deliver safe care for patients undergoing invasive procedures throughout the patient pathway. The standards prevented incidents which adversely affected the patient's well-being and never events including wrong site surgery or intervention; wrong implant/ prosthetic; and retained foreign object post-procedure.

Nursing and support staffing

- There were adequate nursing staff levels to safely meet the needs of patients. At the time of the inspection staffing levels appeared appropriate in the ward, day surgery unit and theatre departments.
- Nurse staffing levels as at 1 July 2016 showed a total of 31.9 whole time equivalent (WTE) in theatre with a total of 9.7 WTE for operating department practitioners (ODP) and healthcare assistants. Nursing for inpatients showed a total of 12.6 WTE and 4.1 WTE healthcare assistants.
- Nursing hours per patient day were allocated according to patient type or dependency. Labour management tools were in place to calculate nursing hours required according to workload, versus actual nursing hours worked, and calculating the variance on a daily basis. Nursing hours were calculated per patient depending on the type of surgery. For example patients for joint replacement required six hours in a 24 hour day, general surgery inpatients 5.25 hours and day cases 2.25 hours.
- Nursing levels were displayed on a board within the ward area, including the name of the nurse in charge, the physiotherapists and the duty doctor. Staffing levels were recorded on a daily basis and reviewed by heads of department.
- The management of non-employed staff members such as visiting consultants, agency workers, was outlined within local management protocols. The use of a temporary workers' checklist was inherent within these processes.
- There were no agency or bank nurses or health care assistants working in theatre departments in the last three months of the reporting period July 2015 to June 2016. This rate was lower than the average when compared to other independent acute hospitals. The percentage of agency and bank nursing staff on the ward during the same period ranged from 6.1% to 13.9% and for healthcare assistants ranged from 6.4% to 26.6%.
- There were no vacancies in theatre, however, there were 2.5 WTE vacancies on the ward. Staff recruitment had been challenging with a poor response to recent adverts

both in terms of number and quality of respondents. Staff turnover was monitored on a monthly basis, for August 2016 it was 9.84% and for September had risen slightly to 10.44%.
- Sickness for August 2016 was 1.00% and 0.97% for September.

Medical staffing

- There were adequate medical staffing levels to safely meet the needs of patients. There were 20 doctors employed as at July 2016. The medical director and the hospital director met at the fortnightly senior management team to review medical staffing requirements within each medical speciality. Calculations were based on expected procedures in theatre. The professional registration of every doctor employed was validated prior to the commencement of their employment, and then annually thereafter.
- The resident medical officers were outsourced. One resident medical officer (RMO) was present on site 24 hours a day, seven days a week and would escalate concerns immediately to the consultant on call. RMOs had access to a clinical support helpline 24 hours a day, seven days a week. Actual working time and workload was monitored and reconfigured where appropriate. With the current duty shift model, the RMOs had one to two weeks off between shifts as downtime which allowed time to recover between shifts.
- The medical director maintained their clinical practice which meant they were regularly performing surgery and receiving feedback from patients and staff.
- There was a clinical staff on call rota 24 hours per day, 365 days per year. Surgeons and anaesthetists on call rotas were published weekly by speciality including anaesthetics and this included out-of-hours, overnight and weekend cover. They were available to attend the site, to undertake emergency procedures and to give advice or guidance.
- The inpatient ward provided 24 hour care, theatre and recovery departments worked from 7am to 6pm. On call theatre and recovery rotas were published by the theatre manager on a weekly basis and disseminated throughout the site.
- All staff were directly employed and salaried on a permanent or bank basis, with the exception of two orthopaedic surgeons and the gastro-enterologists, who were self-employed. All members evidenced compliance to all the HR recruitment procedures.
- Doctors' annual leave was co-ordinated to ensure that no more than two were absent at once. They were also required to give eight weeks' notice in order to maintain capacity.
- There were concerns about the lack of a lead anaesthetist to develop and lead the service. Recruitment had been challenging and options and alternatives were being considered.
- We saw the allocation of supporting professional activities (SPA) days for anaesthetists in the year October 2015 to September 2016. All consultants were entitled to one SPA day per fortnight worked. Calculations were based on 44 weeks worked per annum (52 weeks minus six weeks annual leave and two weeks of continued professional development (CPD) leave) giving a total of 22 days per year. Data from the anaesthetic rota showed that all exceeded the allocation with one member of staff having an allocation of 24 days during a 10 month period and one of 38 days.

Emergency awareness and training

- There was a standard operating procedure which outlined the decisions and actions to be taken to respond to and recover from a range of adverse incidents causing disruption to services. This complemented the existing corporate policy. Potential adverse incidents included failure of the electronic referral system, failure of the telephone system, water supply failure or leak, adverse weather conditions, significant local road disruption, major incident in the county, major equipment failure, medical gas failure, missing patient, epidemic and the loss of a specific service.
- Staff reported fire alarms were tested regularly and staff were aware of where and how to evacuate patients. Annual fire drills were completed and fire marshals were appointed.
- On the instruction of the local commissioning group, the hospital was required to take patients who were almost ready for discharge from local acute NHS hospitals in the event they had a major incident and needed to free up bed space..

Are surgery services effective?

Outstanding ☆

Surgery

Outstanding ☆

We rated effective as outstanding because:.

Evidence-based care and treatment

- Policies and guidelines reflected evidence based care and treatment and had been developed in line with national guidance. These included the National Institute for Health and Care Excellence (NICE). Some examples included NICE QS49 for surgical site infections, NICE NG45 for pre-operative tests and NICE QS3 venous thromboembolism in adults. Staff provided examples of NICE guidelines followed in the hospital and they said they were notified of any new guidelines or Department of Health Central Alerting System (CAS) alerts at department or governance meetings.
- The hospital followed guidelines for day case and short stay surgery approved by the British Association of Day Surgery (BADS) and Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the Association of Perioperative Practice (AfPP guidelines). Staff said they adhered to these policies and procedures and they were easily accessible electronically.
- Patients had their needs assessed and their care planned and delivered in line with evidence based guidance, standards and best practice. Compliance was monitored through a comprehensive audit schedule. If audit compliance fell below 95% managers would complete an action plan.
- Professional guidance was followed by recording and managing implants. All patients who underwent joint replacement surgery consented to have their prosthesis registered on the National Joint Registry. This was done to contribute to the ongoing monitoring by the NHS on the performance of joint replacement implants, the effectiveness of different types and to improve clinical standards.
- Extensive clinical pathways had been developed for the delivery of treatment along with a suite of risk assessment tools and clinical outcomes. The clinical outcomes were made up of key performance indicators (KPIs) some of which were generic for example cancellations, surgical site infections and falls. Some were speciality specific, such as orthopaedics: dislocation and limb length discrepancy; ophthalmology: endopthalmitis and corneal abrasion. The outcomes were reported against the clinical episode which enabled the local governance team to extract the data by procedure, speciality and surgeon. This data was the foundation of all governance reports. The clinical governance team were able to benchmark performance, identify any trends, recognise any outliers, and to discuss individual performance with the medical director.
- KPI and clinical outcomes were also in place for patients transferred from local acute hospitals for general surgery and orthopaedic surgery.
- There was a set of quality and performance indicators which were reported monthly and any deficits resulted in the formulation of an action plan. The speciality specific clinical outcomes and thresholds reflected national evidence based guidance and practice. The governance system included the review of all published guidance within the month, the appropriateness of this in terms of practice and, if appropriate, amendment to policies, standard operating processes and guidelines.
- Local safety standards had been developed to set out the key steps necessary to deliver safe care for patients undergoing invasive procedures from admission to procedure and discharge. The standards included the local governance processes in terms of audit, local reporting and learning, quality improvement initiatives, reporting KPI performance, management of risk and documentation.
- The electronic patient record system enabled clinical outcomes to be captured against each patient episode of care. They were correlated by procedure and by surgeon which enabled the information to be used to form the surgeon annual scorecard for their appraisal. Each clinical outcome was assigned a threshold for reporting based on percentage terms and relating to activity.
- Endoscopy services were awarded Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation in October 2015. This was a re-accreditation of an initial award made in 2010.
- The hospital's central sterile services department had a British Standards Institution (BSI) certificate of registration for the provision of their service of decontamination and moist heat sterilisation of surgical instrument sets. An unannounced BSI inspection found full compliance with international organisation for standardisation (ISO).

Pain relief

- All patients said their pain was regularly monitored and pain relief was administered when required. As part of the discharge electronic patient feedback questionnaire patients were asked 'did the staff do all they could to help control any pain?' Results from inpatients and day case patients showed pain was controlled for all patients.
- Pain was also discussed at the morning ward round. This was discussed in detail to include pain levels throughout the day and any pain relief required.
- We also observed good practice of administering pain relief in recovery.
- There were various measures used to prevent and treat pain. After surgery patients were asked on a regular basis to score their pain on a scale of zero to ten with zero being "no pain" and ten being "worst pain ever." Patients were also asked to say where their pain was and what it was like, for example was it "aching, burning, pulling, stabbing."
- Pain treatment options varied depending on the type of surgery and ranged from tablets, capsules or liquids to swallow, patient controlled analgesic or nerve block injection.
- Pain audits were carried out at regular intervals throughout the patient pathway. The National Early Warning System (NEWS) for patient observations was used which included pain as a parameter.
- Within the discharge pack patients received information on the pain relief they were provided with to take home.

Nutrition and hydration

- Patients were advised about fasting instructions prior to surgery as part of their pre-operative assessment. This included when and what patients could eat and drink.
- Breakfast, lunch and dinner were provided to patients on the inpatient ward, and menus identified nutritional requirements. In the day surgery unit patients were provided with tea, coffees and biscuits.
- As part of the nursing inpatient admission documentation all patients had a high level of nutrition screening using the Malnutrition Universal Screening Tool (MUST) a validated nutrition screening tool which identified patients who were malnourished or at risk of malnutrition. The inpatient team undertook nutritional audits to ensure that 100% of all patients were screened within 24 hours of admission. Screening occurred on admission and then daily.
- We saw chilled bottles of water were available and patients told us they were replenished regularly throughout the day. Hydration was monitored through fluid balance charts which were completed by all staff whenever the patient was offered fluids. The fluid balance charts were audited monthly. The National Early Warning System (NEWS) for patient observations included fluid balance as a parameter. Patients were asked to complete a departmental specific feedback questionnaire prior to discharge, one of the questions asked was "How would you rate the food?" Results from inpatients showed a unanimous satisfaction with the food during their stay.
- The centre had received the gold Soil Association Food for Life Catering Mark which indicated a good appreciation of the connection between diet and health. The head chef and the team were commited to providing meals that were all freshly prepared and of the best quality. Organic produce was locally sourced and there were approved buying lists.
- Catering services provided food provision every day, seven days per week for patients, and café services (offering hot, freshly prepared food) five to six days per week. Catering was also available for hospitality and charity events.
- There were four menus per year featuring seasonal changes. There was a seven day cycle and 13 dishes were available per service. Additional food was available for patients at times outside of kitchen service if patients were hungry; including hot meals, fruit, sandwiches, cheese and biscuits.
- Dietary needs were well managed. There were daily chef visits to the inpatient ward to ensure that there was an immediate response to patient's needs and nutrition advice. Alternative versions were available and allergens were identified on allergens sheets. All menus could be replicated for most dietary requirements using appropriate ingredients, for example gluten free versions. Vegan requirements were accommodated and cultural requirements were managed, for example Halal meat was sourced locally. Patient needs were identified before their arrival as part of the pre-assessment process.

- Results from the patient led assessment of care environment audit of the taste of food had achieved a score of 93%.

Patient outcomes

- A number of regular audits were carried out to monitor performance against national patient outcomes and to maintain standards. Action plans were in place following participation in audits to address areas requiring improvement. Regular reviews were undertaken to monitor progress.
- An audit schedule informed services about their requirements for undertaking and submitting a range of audits that were required to review and demonstrate quality and safety of services delivered. This schedule identified which audits were required to be completed and in which particular month. It also highlighted the submission date.
- The hospital participated in the national Patient Reported Outcome Measures (PROMs) for knee and hip arthroplasty and groin hernias. PROMs indicate how patients perceive their own health benefits following a number of surgical interventions, including hip and knee replacements, based on responses to questionnaires before and after surgery.The answers to these questions were submitted to a national data base which analysed the effectiveness of care.
- Data from the Oxford Knee Score, a threshold for knee replacement, showed the rate of improvement for the period between 1 April 2015 to 31 March 2016 was 95.3%. This was an exceptional score and exceeded the national rate of 93.6%. The hospital was rated top in the area for knee replacements and shared the top position for hip replacements for Oxford Hip Score with two other independent hospitals in the south west. Over the past year 314 patients had knee replacement surgery with a further 435 having hip replacements.
- Targets were achieved to develop and implement local PROMs for hand procedures, enhanced pain management and a falls and stability programme. There had been a reduction in falls at one year follow up of lower limb patients, who were at high risk of falls who had participated in the falls and stability programme.
- There were 11 unplanned readmissions to surgery within 28 days of discharge between July 2015 and June 2016. There were six cases of unplanned returns to the operating theatre and eight unplanned transfers of inpatients to other hospitals in the same reporting period. The numbers were not high when compared to a group of independent acute hospitals who submitted performance data to CQC.
- Compliance to local safety standards for invasive procedures was audited and covered workforce, scheduling and list management, handovers and information transfer. Other areas included procedural verification of site marking, team briefs, sign in, time out, prosthetic / implant verification, prevention of retained foreign objects and de-brief.
- An audit summary report for September showed 99% to 100% compliance and included venous thromboembolisms (VTE), fluid balance, peri-operative hypothermia, World Health Organisation (WHO) surgical safety checklists and WHO observational ward round. An audit of the National Early Warning Score (NEWS) showed a compliance status of 82%. An increase in the number of agency staff had accounted for the drop in the audit score and staff were regularly reminded to complete scores at staff team meetings. The sensitivity of the audit tool was also considered to be a contributory factor. If one entry was missed or miscalculated out of approximately 100 entries the audit score would drop by 8%. This had been raised with head office.
- Enhanced recovery programmes were followed to help improve patient outcomes. This was done through pre-operative assessments and appropriate planning and preparation before admission and immediately post-operatively.
- Patient discharge advice was provided to patients to improve their outcomes. It included information on managing their surgical wound, pain relief, thrombosis, and returning to their normal routine. Information for compression anti-embolism stockings was provided, to ensure the stockings were worn day and night for six weeks following discharge, to help prevent blood clots forming in the legs.
- All patients received a post-discharge phone call between 24 hours and 72 hours after discharge to review patient progress, provide support and record adverse outcomes.

Competent staff

- Staff had the skills, knowledge and experience to deliver effective care and treatment to patients.

- Annual appraisal and clinical supervision structures enabled staff and managers to identify training needs, develop competence and enhance clinical practice. Data for September showed that 95% of staff had received an appraisal. Staff said there was guidance for the preparation for performance conversations and completion of the process record. Staff felt supported to achieve the goals set during the appraisal.
- Departmental induction, including completion of mandatory training requirements, was finalised within the first twelve weeks of employment.
- There were generic clinical competencies including medicines management, peripheral IV drug administration, fluid balance, aseptic non-touch technique, preparation and administration of blood and blood products for transfusion, nurse consent process in endoscopy and administration of Entonox medical gas.
- There was also a clinical competencies framework including Nursing and Midwifery Council (NMC) essential skills cluster for registered nurses, care, compassion and communication, organisational aspects of care, infection prevention and control, nutrition and fluid management and medicines management.
- There was a commitment to training and education within the service. Staff told us they were encouraged and supported with training and there was good teamwork. Staff were encouraged to keep up-to-date with their continuing professional development and there were opportunities to attend external training for personal development and growth.
- All training attended was documented on electronic staff records. Managers were informed of training completed and alerted to those staff requiring updates for mandatory training.
- The training manager for Care UK had developed a learning management system to track staff training and compliance across all hospitals in the corporate group. We were shown the system and the training records for staff at the hospital. Each member of staff had access to the system and the manager could see all staff they were responsible for. The system linked directly to all the e-learning packages and a diary was available for staff to book onto training being organised at other Care UK hospitals. The system was fully auditable. For example, the training manager could see how long each learning package took to complete and if staff were getting stuck on the same questions. This information was used to improve the learning and commission new packages.
- A half day was set aside for governance each month which was well attended by staff and allowed training to be provided, and further learning and skills to maintain and improve the competencies of staff.
- Each consultant had their own scorecard which showed how many procedures they had undertaken and how many of their patients had suffered complications. The scorecard also detailed compliments about their care and treatment. These scorecards were used in the consultant's appraisal and to identify any particular problems a consultant was facing.
- The HR manager provided training to hospital and departmental managers in recruitment selection and other staffing issues such as managing capacity.
- The resident medical officers were outsourced, and the provider ensured relevant skills and training was provided. Mandatory core skills training for RMOs were delivered via e-learning platforms and these had to be completed before starting work and were renewed annually (if applicable) thereafter. This was monitored via appraisal processes. Current modules included safeguarding adults and children level three, infection control, information governance, documentation & record keeping, lone worker, blood transfusion licence, dementia, equality diversity and rights and duty of care. Additional training appropriate for local services was available on request. All RMOs were advanced life support (ALS) providers and training was maintained and in date. RMOs participated in on site scenario training. Local induction, familiarisation and assessment for all new RMOs and one-to-one mentorship was provided by a consultant anaesthetist.
- Agency staff were required to complete an induction checklist to ensure they were competent. Training for new equipment was always provided to staff to ensure they were competent in its use.
- Catering staff were supported and encouraged with their skills set through the City and Guilds certificates and NVQ awards in hospitality, catering principles and food production.
- Revalidation training had been provided to support staff with their upcoming revalidation.
- Staff were positive about the quality and the frequency of clinical supervision they received.

Surgery

Multidisciplinary working

- We saw evidence that staff worked professionally and cooperatively across different disciplines. This was to ensure care was coordinated to meet the needs of patients. Staff reported good multidisciplinary team working with meetings to discuss patients' care and treatment.
- All staff worked together to assess and plan ongoing care and treatment in a timely way. All staff felt part of the team and were complimentary about each other and valued each other's input to the team. We observed good multidisciplinary team working across the departments.
- Daily multidisciplinary team ward rounds included the surgeon, ward manager anaesthetist, nurses, physiotherapist and pharmacist. We observed one ward round where pain control and mobilisation were reviewed together with the patient's concerns. Although the ward round was consultant led the team worked together and were actively involved and contributed to discussions. Preparation discussions had taken place prior to the bedside visit with the patient to ensure all clinical issues, care planning and documentation were in place.
- The nursing handover between shifts also conveyed information from consultants, anaesthetists, theatre staff and physiotherapists.
- Briefing prior to a theatre list and debriefing following a theatre list were attended by the theatre team, this gave staff the opportunity to provide feedback and rate the satisfaction of the theatre list. We observed records of briefings held by the theatre manager.
- Good team work was demonstrated in the anaesthetic room, theatre and recovery where the patient was the whole focus of the team.
- The clinical teams were assisted by a dedicated team of administrators. They provided comprehensive support to consultants, doctors and nurses with a host of administrative tasks.

Seven-day services

- The hospital did not provide seven day surgery lists but provided medical and nursing treatment and care 24 hours a day seven days a week. Theatre sessions were run five or six days per week from 7.30am to 4pm based on patient schedules.
- The resident medical officer was available 24 hours seven days a week. There was 24-hour on call cover in place which was planned in advance and circulated throughout the hospital for the management team, consultants per speciality, anaesthetists and theatre teams.
- On call support was provided by clinical services including pharmacy, radiology, central sterile services department and pathology.

Access to information

- Information to deliver effective care was readily available. There was a range of documentation and this was easily accessible. Staff said all relevant medical records were available for inpatients and day cases.
- The hospital used paper patient records and an electronic patient record system. Staff said the electronic patient record was easy to access and use.
- For patients transferred from local acute trusts the notes were reviewed to assess their eligibility for surgery.
- The patient administrators aimed to ensure all information was present prior to the patient's surgery date such as X-rays and pathology results.
- We saw evidence of communication with GPs including information required and discharge summaries immediately following discharge. Staff said they had a good relationship with patients' GPs and were able to contact them for information and likewise GPs could contact the hospital should they require information.
- The medical teams said there was good and quick access to test results and diagnostic and screening tests.
- Standard operating procedures were in place to assure patient confidentiality was maintained at all times within the hospital. These included a clear desk policy, locked screen and regular password change provision. Access to patient health records was controlled, with access rights being granted dependent on job role. Confidential information was destroyed on site, via a contract with an external provider.
- Some staff said that not all IT systems interfaced efficiently and could cause frustration and delay in timely data entry.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most staff were aware of consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Deprivation of Liberty

Safeguards (DoLS). Staff had attended mandatory training and knew what their responsibilities were and how to apply them within everyday practice when required.

- Staff acted within the legal framework to obtain patient consent for treatment. Written consent was completed pre-operatively in the outpatient clinic and verbally checked again on admission and as part of the World Health Organisation (WHO) safe site surgery checklist. On admission we observed the consent being checked by the consultant with the patient and everything being explained to ensure the patient's understanding. The operating department practitioner also checked the operation with the patient and their consent. Consent was checked with the whole team present in the anaesthetic room and in theatre.
- Staff were aware of their responsibilities to ask patients for consent for all activities and written consent required for invasive and surgical procedures. We observed staff obtain patient consent verbally for care and treatment throughout the patient pathway.
- We looked at five medical records and saw consent documents were fully and clearly completed.
- There was a policy relating to Do Not Attempt Resuscitation (DNAR) and Advanced Decisions. Staff were aware of their responsibilities. A full entry was made in the patient's medical notes as soon as a DNAR order was made. This included the rationale behind the decision, together with a review date and any other relevant comments concerning the patient's individual circumstances. A copy of the DNAR order was placed on the patient's case notes; it was the first document that was seen. The DNAR decision was effectively communicated to all medical and nursing staff involved in the care of the patient. The responsibility for this rested entirely with the practitioner making the decision.

Are surgery services caring?

Outstanding ☆

We rated caring as outstanding because:.

Compassionate care

- Throughout our inspection, we saw patients being treated with the highest levels of compassion, dignity and respect.
- A policy provided guidance and procedures on respecting privacy and dignity at all times and for ensuring patients and carers were treated with courtesy and respect.
- Staff at all levels demonstrated compassion in every element of the care and service they provided. We observed excellent interactions between staff and patients, and their relatives. These interactions were very caring, respectful and compassionate. The staff were skilled in talking in an open and approachable way but always remained professional.
- We also observed staff whilst they provided care and support. We noted they took great care to explain what they were going to do and how they were going to do it, and ensured each patient and relative, if appropriate, were happy for the care to be undertaken. They involved and encouraged patients to be partners in their own care.
- We saw all staff making an honest effort to understand the personal, cultural and social needs of patients.
- The hospital used the NHS Friends and Family Test to find out if patients would recommend their services to friends and family if they needed similar treatment or care. The response rate was above the England average and ranged from 70% to 84% during the period July 2015 to June 2016. There were positive results with data from this period showing that 100% of patients would be either likely or extremely likely to recommend the service to friends and family if they needed similar treatment or care.
- The patient led assessment of the care environment (PLACE) scores for the hospital as a whole showed that from February 2016 to June 2016 91% of patients felt they were treated with privacy and dignity. This was above the England average of 83%.
- Patients said staff responded immediately to call bells. We observed this response during our inspection.
- Patients and their relatives we met were unanimous in their praise for the service they received. They said all staff went the extra mile and the care they received exceeded their expectations. All the feedback we received was overwhelmingly positive. The comments we received included, "the staff have been fantastic", "and "staff clearly love their work … they go beyond the expected." One patient said the staff were "so good …

they must be hand-picked … they're all so caring," and another said **"**I've been treated with dignity and respect and felt listened to. I can't thank everyone enough for their gentleness and constant care." A relative told us the "staff are passionate about what they do. They are totally committed. We've had nothing but kindness shown."

- The patient led assessment of the care environment audit results for 2016 showed the hospital scored 91% for patient privacy, dignity and well-being which was better than the England average.
- Data from the annual staff survey for 2016 showed 96% of staff said the care of their patients was their top priority and 95% said where they would go the extra mile to provide quality care to patients. All staff were confident that all members of the team had embedded compassion into every aspect of care they were were delivering.
- We observed good attention from all staff to patients' privacy and dignity. Curtains were drawn around bed spaces for intimate care or procedures, and doors were closed in private rooms when necessary. Voices were lowered to avoid confidential or private information being overheard. Care from the nursing, medical staff and support staff was delivered with kindness and patience. The atmosphere was calm and professional without losing warmth and reassurance.

Understanding and involvement of patients and those close to them

- Patients were involved in every stage of their care and treatment. Patients said all procedures had been explained and they felt included in the treatment plan and were well informed. This included the consultant explaining the surgery events in detail to the patient and nurses talking patients through information leaflets. Relatives we spoke to told us they felt involved in the treatment decision making process.
- We observed staff explaining things to patients in a way they could understand. For example, during a complex explanation, time was allowed for the patient to ask whatever questions they wanted to. One patient commented that they had been "updated on everything in a language I understand. The surgeon explained everything to me."
- Patients and relatives were encouraged to be involved in their care as much as they felt able to. Patients we spoke with all confirmed this was the case.
- Staff recognised when patients needed additional support to help them understand and be involved in their care and treatment. They were knowledgeable about the framework to support communication with patients who were non-English speakers, or for whom English was a second language. Support was also available for patients with hearing or visual impairment, or who had learning disabilities.
- We observed a ward round, where the patient was the focus and included in discussions and asked if they had any questions. Patient's concerns were addressed immediately and a plan of action was discussed and agreed with the patient.
- Staff made sure patients knew who the staff were and what they did. All healthcare professionals involved with the patient's care introduced themselves and explained their roles and responsibilities.

Emotional support

- We observed staff providing emotional support to patients and their relatives. Patients' individual concerns were promptly identified and responded to in a positive and reassuring way. One patient said that "nothing was too much trouble for the staff … from the doctors and nurses to the administration team."
- We observed patients in theatre, where staff throughout the procedure were calm and supportive. Staff recognised the patient's anxieties and provided reassurance to put the patient at ease.
- Patients were spoken with in an unhurried manner and staff checked if information was understood. When staff telephoned patients following discharge we overheard staff encouraging them to call back at any time if they continued to have concerns, however minor they perceived them to be.
- Staff understood the impact the care, treatment or condition might have on the patient's wellbeing and on those close to them both emotionally and socially. One patient told us "the doctors and staff here have been amazing. They've supported me through lots of operations … there have been lots of tears. I couldn't have faced things without them. They've turned my life around".
- There were an array of thank you cards and messages on display from patients and relatives expressing their gratitude for the support and care they received.

Outstanding ☆

Surgery

Are surgery services responsive?

Outstanding ☆

We rated responsive as outstanding because:

Service planning and delivery to meet the needs of local people

- The hospital had planned its activities around the needs of the local population. Local GPs and commissioners were involved in planning services and this had led to a successful bid to work in partnership with a local NHS trust to develop health services across the county.
- The environments in theatre and on the ward were designed to meet the needs of patients.
- Theatre sessions were run five to six days a week from 7.30am to 4pm and allowed some flexibility and choice for the local population. Activity in theatres was planned and reviewed at weekly scheduling meetings. Theatre sessions were scheduled to meet the needs of the patient and activity with some Saturday sessions when required.
- Staff were responsive in dealing with changes and delays. We observed changes being communicated to patients and apologies provided.
- Arrangements were made to ensure single sex accommodation on the ward and day surgery unit.
- There was parking on site although a couple of patients said it had been difficult for their relatives to park on busy days. Public transport was limited in the county and in order to help patients from towns, villages and hamlets across the county there was a free bus service offering access to the centre for those with transport difficulties. The service was restricted to patients meeting certain criteria, usually those attending ophthalmology and some orthopaedic procedures. However, requests from patients who did not meet the criteria would be considered by managers.
- All areas of the treatment centre were accessible to wheelchair users. Portable hearing loops were available at the main reception desk and could be carried around the treatment centre as required.
- Accommodation comprised 11 two-bedded and four three- bedded same sex, en-suite rooms.There was free TV and Wi-Fi access for patients and free telephone calls. There was a flexible visiting policy with visitors welcomed daily with the exception of lunchtime between 12.30pm and 1.30pm. There was a café available on the ground floor for relatives.
- Patient information was available in a range of languages, large print and Braille on request from the main reception desk. An interpretation service was available to support patients if English was not their preferred language.
- The hospital was actively developing the health and wellbeing agenda with the collaboration of several groups in order that the needs identified within the Somerset CCG Joint Service Review were achieved. Care UK had established a local community participation group which met bi-monthly with 30 representatives of community groups, meeting together to discuss key priorities for service users within the local community.
- The hospital had responded to patient feedback “You Said, We Did”. An example of this was the ability to choose the size of a meal and the availability of a hot evening meal for patients who had undergone day case surgery. The patient forum had also requested more support post discharge of joint replacement and as a result a post-operative knee class was commenced.
- Patients had commented they felt vulnerable from falling in the first year post surgery. As a result a falls and stability class was set up and the outcomes had been audited and demonstrated a positive reduction in the number of falls within the first year.
- Other responsiveness to patient needs included staggered admission times so that patients were not waiting too long before their surgery; information and post discharge support was provided with procedure specific leaflets and a 24 hour help line staffed by healthcare professionals.
- A post discharge follow up phone call had been introduced for all patients at 24 hours to 72 hours after discharge to check that they were recovering well.

Access and flow

- Patients could access treatment and care in a timely way. There was a dedicated flow through theatre schedule with flexibility to make adjustments to the list.
- Standard operating practices and processes were in place to ensure that procedure lists accurately reflected the plans for the patients, and the procedures they were scheduled to undergo.

- Patient activity was planned in advance. Staff allocation was planned according to scheduled theatre lists and inpatient stays. Schedules were reviewed three weeks in advance and locked ten days in advance. Scheduling of procedures included agreed fixed time for team briefs at commencement of lists; the allocation of appropriate turnaround times between procedures; and a fixed time for team de-brief at the end of the list.
- Team briefs were led by the senior healthcare professional in charge of the list. Team brief / de-brief documentation was returned to the theatre manager at the end of the working day who audited completion. The theatre manger attended team briefs at least three days a week.
- The protocol identified actions required in the event of unexpected changes within the list order, staffing expectations and changes within the team intra-operatively. Any requests to change the schedule once it had been released were made using a scheduling change request form. There were booking rules relating to priority of patients and during our visit the list was changed to accommodate a diabetic patient. The change was seamless and the patient was seen earlier in the day.
- The hospital worked to a ten week contractual pathway and had introduced a referral management page to the electronic patient record, to improve the capture of data during the patient episode. This enabled the population of a weekly wait time report which was published on the web site and to the referral management centre. In addition to this, the local booking team received a weekly speciality specific waiting times report to ensure that patients were booked in breach order. As a response to any increase in wait times, and as part of the weekly capacity planning meetings, the schedule was reviewed to see if any additional activity could be introduced with the specific purpose of reducing the wait time. Indicative waiting times were captured on a weekly template with results for the week of our inspection showing: general surgery between four to five weeks; gynaecology eight weeks; ophthalmology four to seven weeks; orthopaedics three to eight weeks and urology five to six weeks.
- Above 90% of patients were admitted for treatment within 18 weeks of referral during the period July 2015 and June 2016.
- Patients said they were happy with the access they had to their treatment. We were told they were able to come to hospital at a time suitable for them. One patient explained how they were able to defer their surgery for a more convenient time.
- Patients were phoned five working days before their admission date to confirm the time and ensure they had the appropriate information prior to their surgery. This was recorded on the electronic patient record.
- Delays in theatre would be communicated to patients who were waiting in the day surgery unit. There was also scope for patients at home to be contacted to delay their admission time. Any cancellations would be explained to the patient and an apology provided, the patient would be rebooked as soon as possible.
- The orthopaedic enhanced recovery pathway was following an average length of stay for hips of 2.4 days and for knees 2.5 days. There were 2,918 referrals and 2,145 theatre admissions. There were 0.09% of patients returned to theatre, 0.09% unexpected transfers to another provider and 0.14% for revision surgery.
- There were 7,760 inpatient and day case episodes of care recorded at the hospital in the reporting period July 2015 to June 2016. In the same period there had been 64 cancellations of procedures for a non-clinical reason of which 64 were offered another appointment within 28 days.
- During the reporting period July 2015 to June 2016 there were 1,833 day case admissions of which five (0.27%) were inpatient admissions, 33 (1.54%) clinical cancellations, 25 (1.17%) of non-clinical cancellations due to equipment failure, booking errors or where the patient did not wish to proceed. There were two (0.56%) inpatient DNAs and late cancellations.
- The most common surgical procedures included cataract extraction and lens implant, gastroscopy, colonoscopy, hand procedures, hernia, hip replacement, knee replacement, arthroscopy and feet procedures.
- We observed a patient being discharged from the day surgery unit. There was involvement of both the physiotherapist and the nurse prior to the discharge. A discharge checklist was completed and clinical outcomes discussed. The patient was provided with a comprehensive discharge pack.

Meeting people's individual needs

- Patients were treated as individuals with treatment and care being offered in a flexible way and tailored to meet their individual needs.
- A patient's individual needs were established at referral or during the pre-operative assessment in outpatients. Staff were able to make arrangements to appropriately accommodate, where possible, individual needs during a patient's admission, surgery and inpatient stay. All staff had an understanding of meeting the needs of different people. Discharge planning was incorporated as part of the pre-assessment process.
- All areas we visited were accessible for wheelchairs and there were appropriate toilet facilities. The patient led assessment of the care environment (PLACE) scores for the hospital confirmed this with a score of 96% compared with the England average of 81%.
- A varied menu had meals to accommodate individual needs. The head chef was very proud to tell us that all dietary needs could be met including; suitable for diabetics, low fat, low calorie, moderate salt, gluten free, vegetarian, soft food and healthy options. All menus could be replicated for most dietary requirements using appropriate ingredients. Patients said they were happy with the food provided and snacks were available outside of meal times should they still be hungry. Patients were provided with regular hot drinks and chilled water and drinks were in constant supply. Hot drinks and biscuits were also available for relatives.
- A dementia strategy was in place which aimed to ensure the service was provided at the right time, in the right place and the right support was offered to patients with a confirmed or suspected diagnosis of dementia and delirium. There were plans to introduce a dementia link nurse to each service area with a responsibility for measuring and monitoring performance against key performance indicators (KPIs), policies, procedures and best practice guidance.
- A 'This is Me' document was used to help staff improve care for patients living with dementia. This was a practical tool that carers could give to staff when a person with dementia went into hospital. It gave an insight into the person's world beyond their diagnosis, including their life history and family background, so that staff had a full picture of the individual they were looking after. A dementia friendly room was also available close to the nursing station. It had appropriate wall colouring, an easy read clock and two beds to allow carers to stay with the patient if required.
- An interpretation service was available to support patients if English was not their preferred language.

Learning from complaints and concerns

- The hospital had policies and processes in place to appropriately investigate, monitor and evaluate patient's complaints. Corporate and local policies were developed in line with the patient association standards toolkit.
- The patient quality and safety manager was responsible for the management of complaints. This role included liaising and providing support to the complainant and staff involved in the complaint. The manager was responsible for keeping accurate documentation of the complaint and management process, investigating the complaint, identifying root causes and contributory factors and lessons learned. They were also responsible for drafting the final response and reporting the complaint and final outcome via the monthly clinical governance meeting and the quarterly CCG review board meeting. The hospital director was responsible for reviewing the root causes and draft letter of response and signing off the final version.
- All complaints, concerns and compliments, were recorded on an electronic reporting system. An automatic notification was sent to the senior management team when a new complaint was added. Monthly reports were created and integrated within the clinical governance report, split into three distinct headings to enable immediate recognition of the number and type of feedback. This was discussed at the monthly clinical governance meeting which was multidisciplinary and open to all staff members, including the senior management team and formed part of the standard agenda. The subject matter of the complaint, root causes, contributory factors and lessons learned were discussed and any actions agreed. This meeting encouraged open discussion and shared learning and was valued protected time when clinical activity was suspended to allow as many staff members as possible to attend.
- In addition to this multidisciplinary meeting, any clinical issues arising were discussed at the monthly clinical head of department meetings to ensure learning was disseminated. The hospital also participated in the quarterly commissioners' complaints management

meeting in which a synopsis of complaints received in the quarter were discussed and any common themes identified. This provided a further opportunity to share lessons and actions to prevent reoccurrence.

- During the period from July 2015 to June 2016 there had been 21 complaints. One complaint had been referred to the Ombudsman in the same reporting period.
- A common theme within several complaints was that the patient had been given expectations of actions from one department, stating that an alternative department would take action within a short time scale. Each of these had been discussed at head of department meetings, to encourage inter-departmental understanding, and to check feasibility of actions prior to advising the patient. This ensured the patient's expectations were more realistically managed.
- Patients knew how to make a complaint if they needed to and also felt they could raise concerns with the clinical staff they met. Patients told us if any issues arose they would talk to the senior nurse available. Information about making complaints was available in all the areas we visited.
- "Have your say cards" for NHS choices were provided to patients in their discharge pack and feedback on NHS choices and social media were regularly monitored.
- Staff were able to explain what they would do when concerns were raised by patients. They said they would always try to resolve any concerns as soon as they were raised, but should the patient remain unhappy, they would be directed to the clinical manager. Staff were aware of complaints and any learning that had resulted.

Are surgery services well-led?

Outstanding ☆

We rated well-led as outstanding because:

Leadership / culture of service related to this core service

- The local leadership of the surgical services had the skills, knowledge and integrity to lead the teams.
- The clinical managers were an experienced and strong team with a commitment to the patients who used the service, and also to their staff and each other. They were visible and available to staff, and we saw and heard about good support for all members of the team. We received consistently positive feedback from staff who had a high regard and respect for their managers. One member of staff told us their manager "was brilliant… they are always out and about… always able to come up with an answer." Another described their manager as "very loyal and will bend over backwards to help .. they make sure we know everything as a team."
- The senior management team communicated with staff by email and face-to-face. We received consistently positive feedback from staff who had a high regard and respect for the management team. They were visible, approachable and supportive and one member of staff said they "always had time for staff … I feel very supported." Another said they felt "confident in the team to steer us through the rocky waters ahead."
- Through the content of governance papers and talking with staff, we saw the leadership of the unit reflected the requirement to deliver safe, effective, caring and responsive and well-led services.
- Managers encouraged learning and a culture of openness and transparency. They had an awareness that staff required different leadership styles and were flexible in their approach to the needs of their teams.
- Staff told us they were not frightened or worried to talk to their managers if something had not gone as planned.
- The hospital was committed to developing, supporting, and sustaining a diverse workforce and creating a working environment where everyone was able to do their job to the best of their ability without having to face discrimination or harassment.
- There were high levels of staff satisfaction across all departments and job roles. Staff were eager to share with us how much they enjoyed working at the hospital and were very proud to work at the hospital. Staff spoke very highly of the culture. Comments from staff included: it's a very special place to work," "I enjoy coming to work," "I know I make a difference."
- The staff we spoke with during the inspection said they were proud to work on the units and were passionate about the care they provided. Managers we spoke with said they were proud of the staff they supervised. They said there was a high level of commitment to providing quality services to patients. One member of staff told us,

"I feel supported by my colleagues and a valued member of the team … we are like a family and do the best we can." Another member of staff told us, "this is the most welcoming hospital I've worked in."

- Staff were positive about working for Care UK, although there were some anxieties about the future as the hospital entered a transition phase following the successful award of the new contract to develop the health and wellbeing campus. Staff were concerned about the uncertainty of the change process and the impact on their their job security.
- Staff said they were encouraged to raise concerns. All staff felt comfortable about raising any concerns with their line manager. They were aware of the whistleblowing policy and the arrangements for reporting poor practice without fear of reprisal. They felt confident about using this process if required and that concerns would be taken seriously.
- Staff told us that they were always keen to learn and develop the service. Innovation and improvement was encouraged with a positive approach to achieving best practice.
- It was apparent during our inspection that all the staff had the patient at the centre of everything they did. They were dedicated to their roles and approached their work with flexibility.

Vision and strategy for this this core service

- The vision for the coming year included being Somerset's leading independent provider of NHS elective care services. Shepton Mallet Treatment Centre was entering a transition phase following the successful award of a new contract with another provider to develop a health and wellbeing campus. This contract would commence in 2017, and was for eight years with an option to extend for up to two further years.. This would remain a key focus throughout the year.
- The senior management team annually reviewed the strategic objectives for the next year in line with the Care UK Board and the clinical commissioning group. The hospital director identified these in a visual format which was locally referred to as the 'Shepton Mallet Treatment Centre temple'. From this, each department was able to develop their own visual strategic objectives which outlined the quality and business objectives for the next year. Each head of department was asked annually to review their departmental objectives for the coming year in line with the centre's objectives and through this process departmental 'temples' were produced. These visual documents were displayed within departments and were reviewed as part of monthly departmental meetings.
- There were objectives for reception, bookings team, medical records, catering / housekeeping, administration, governance, pharmacy, diagnostic imaging, medical staff, outpatients, and physiotherapy. Theatre objectives included theatre efficiency, reducing turnaround times, recruitment for theatre, controlling overtime / agency use and meeting the demand in extra capacity.
- Ward objectives included progressing and monitoring the risk assessment for urinary catheter insertion, maintaining staff turnover at less than 10%, encouraging patients to return to the ward clinic for dressings and checks, managing patient discharges to ensure they were discharged in a timely manner whilst maintaining safety to avoid returns and establishing new partnerships with the community hospital staff.
- The values of the hospital were integrated into each member of staff's performance review. These values included: "Every one of us makes a difference", "Customers are at the heart of everything we do" and "Together we make things better."
- The quality account measures had been set and the Commissioning for Quality and Innovation (CQUIN) had been negotiated and these two elements formed the quality assurance strategy for the coming year and were managed by the governance team. There were four CQUINs relating to patients, staff well-being, IM&T and antimicrobial stewardship.
- The senior management team set clear objectives for their departmental leads through regular team meeting schedules. The hospital director held monthly heads of department meetings to ensure staff were aware of new developments and listened to feedback from the local teams. The head of nursing and clinical services held monthly clinical heads of department meetings where site objectives, clinical service developments and governance issues were discussed. The local governance team and medical director held monthly governance and morbidity and mortality meetings to which all staff were invited. These meetings were well attended and promoted reflective and healthy discussion which supported an open and fair culture.
- Site led speciality meetings were held bi-monthly. Key staff attended strategic meetings and then gave

feedback to the local teams. This schedule of meetings was supported by departmental meetings which allowed a two-way communication channel from ward to board. Risks, incident trends and adverse clinical outcomes were reviewed by the senior management team and where necessary action plans were formulated. Through regular review of the audit results the heads of department were able to identify gaps in staff competence and then through discussion with the senior management team additional learning could be identified.

- The senior management team had developed a quality management system that provided the framework and the associated processes to ensure that patients' expectations were met in a timely and consistent basis. As part of the commitment to achieving compliance, the management team set out strategic objectives that were reviewed periodically to ensure they remained applicable. Additionally, it was the responsibility of the management team to ensure that all employees within the hospital were aware of the quality policy and understood the importance of, and their role in achieving compliance with, the quality management system.
- The multidisciplinary senior management team, provided visible and accessible leadership to the local teams on a day to day basis. There was a senior manager on the on call rota which ensured that the same level of leadership and expertise was available outside of working hours.

Governance, risk management and quality measurement

- Governance and risk management processes were robust and fit for purpose and demonstrated a very positive working relationship between all staff teams and the senior management team.
- The governance framework was focused on supporting the delivery of safe, quality care. There were clear reporting structures from the department up to the senior management team and vice-versa. A variety of meetings fed into the quality governance assurance meetings which ensured a comprehensive clinical and operational oversight at organisational and departmental level.
- The local governance team collated all clinical outcomes, incidents, patient feedback results, audits, horizon scanning, complaints, staffing figures, mandatory training and shared learning into the monthly governance report template.
- Quality governance days were held monthly for all staff. During these governance days, staff attended department and hospital wide meetings with opportunities to undertake training sessions. This ensured all staff were up to date with their training and fully informed about activity and challenges. There was no clinical activity other than inpatient care on these days. We were informed this was well attended by the multidisciplinary team. Staff said this was a great opportunity to be provided with updates and improve competencies and understanding.
- A comprehensive set of corporate policies, was readily available on the intranet and was supported by robust local standard operating procedures and processes. This ensured staff were able to work according to best practice guidance.
- An extensive and proactive audit programme was in place to measure the quality of the services provided by the surgery service. Audits were completed in both the theatre and ward department. Performance data and quality management information was collated and examined to look for trends, identify areas of good practice, or question any poor results. Heads of department had a good awareness of the areas identified for improvement within the audits and demonstrated how learning was shared.
- The service understood, recognised and reported their risks. A full review of risk was undertaken each month. Risks were shown by specialty and risk level and mitigating actions were recorded. A risk register was in place and we noted that this had been kept up to date. Risks were identified on the risk register with actions required and taken and a review date. Each risk had a lead manager that was responsible for progress and management of the risk. The risk register was discussed at regional meetings with other treatment centres from Care UK. The hospital was rated as green for the number of open incidents and for having no incidents that were overdue for review.
- Local safety standards for invasive procedures (SSIPs) were in place and were available as pictorial snapshots of the patient pathway through theatre.

- There were no consultants working under practising privileges at the time of our inspection, and this was not intended to be reintroduced to the hospital processes.
- There was no Medical Advisory Committee (MAC). In independent hospitals the MAC acts as an expert advisory group and supports hospitals in monitoring safe, effective and responsive care. At the hospital, this function was met by various forums at a corporate and local level.

Public engagement

- There were systems to engage with patients and the public to ensure regular feedback on services. This was used for learning and development.
- Patients and carers were encouraged to contribute to service development. The patient forum group ensured a two-way dialogue between the hospital and its patients. The hospital sought input from the group regarding elements of the patient experience and discussed service developments and improvements with previous service users. The members of the group were previous patients that had typically used the services during the previous 18 months. Members served on the group for 12 to 24 months before being replaced with more recent users. Efforts were made to ensure the membership reflected the patient population and the different services used. Membership was open, transparent, socially inclusive and embracing of the equality and diversity agenda. The group was also structured to be geographically representative of Somerset as a whole.
- There were eight former patients making up the group at any time, three of whom would need to be present for the group to be quorate. The service was represented at group meetings by the head of nursing and clinical services and the stakeholder engagement and communications executive. Other senior staff and service leads attended meetings. Representatives had responsibility for ensuring that the output from the group was disseminated appropriately and incorporated effectively into service design and development. Feedback from this process was shared with group members. Group meetings were held no less than twice per year.
- Issues for discussion included: review and discussion of recent patient feedback and survey results; eliciting detailed reasoned input from patients regarding aspects of the pathway; review of patient expectations and perceptions of services. Further issues related to proposed improvements to the patient pathway; discussion of actions planned or being made to improve accessibility of services across the county; discussion regarding the introduction of new services; and reviews of updated patient information from the patients' perspective.
- The patient forum members felt involved and part of the hospital and were able to ask questions to provide challenge.
- The hospital had developed departmental specific patient feedback questionnaires, which were regularly reviewed. This information was fed back to the local team through governance and the 'You said, we did' programme which enabled feedback to develop services. The questionnaires captured friends and family score by department.
- All patients received a business card with details about how they could give feedback. This included NHS Choices, via the website, written paper and electronic, social media and verbal feedback. All feedback was collated and entered onto the electronic patient feedback module and all patients were sent an acknowledgement.
- We saw a lot of patient information leaflets and information sheets including: information to assist patients to make an informed decision about surgery, advice about procedures, how to prepare for surgery and post-operative information. There was also information about a pocket physio easy to use guide to the physiotherapy exercises involved in the preparation for and recovery from orthopaedic surgery and patient discharge advice such as general information about recovery following an operation, when to remove dressings, pain relief, returning to normal routine and follow-up appointments.

Staff engagement

- There were systems to engage with staff. All staff we met said they felt valued and part of the team. They were able to express their opinions and raise concerns through department and organisation forums. Regular meetings and emails provided opportunities for feedback about governance issues such as incidents, complaints and risk assessments. Performance and continuous improvement was also assessed through discussions about essential training, clinical skills and competencies.

- A newsletter was available for staff about the service changes and developments. A staff forum from the hospital and the community hospital was being set up to enable a two-way conduit for communication.
- Thank you cards were on display throughout the hospital to remind staff of their successes.
- Access to counselling was available for all staff through an employee assistance programme. This was a programme based around cognitive behavioural therapy and provided staff with an independent counselling service and a 24-hour advice line.
- We were shown the results from the 2016 staff survey. Questions were divided into the following categories: my work, my contribution, my development, reward, patient and customer focus, leadership, immediate line manager, speaking up, equality and diversity and overall perceptions. The highest scores related to the care for patients being the top priority at 96%, knowing what was expected at 95%, going the extra mile to provide quality care to patients at 95%, knowing senior managers in their area at 95% and feeling proud of the work they did at 94%. The lowest scoring related to satisfaction with pay and benefits at 34%, believing action will be taken in response to the survey at 44%, being updated about what Care UK was doing and future plans at 51%, being motivated to achieve objectives at 51% and being inspired to do the best in their job at 51%.
- All staff we met said they felt valued and part of the team. They said the hospital was an "enjoyable place to work" with a "diverse and interesting range of job opportunities." Staff felt supported by the senior management team, heads of departments and their colleagues. One member of staff said "people make the place .. it's a special place and people go beyond to step in to help colleagues." Staff appreciated a welcome greeting on arrival by the reception staff and other colleagues. A number of staff had also been inpatients at the hospital and told us they "wanted to be looked after by my colleagues as I know they're good at what they do."
- A free meal was supplied to all staff at Christmas and served by the senior management team.

Innovation, improvement and sustainability

- There was a clear focus on looking for potential innovative solutions to continue to ensure the delivery of high quality person centred care. Staff and managers felt there was scope and a willingness amongst the team to develop services.
- At the time of our inspection, the hospital had successfully won a bid to work in partnership with a local NHS trust to provide additional services.
- Work to standardise surgical techniques was ongoing with a commitment to training in techniques.
- There was active participation in the Care UK Equality and Diversity Steering Group which was supporting continuing work in promoting an open and fair culture. It was committed to developing, supporting, and sustaining a diverse workforce and creating an environment where everyone was able to do their job without having to face discrimination or harassment.

Outstanding ☆

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Outstanding ☆

We rated safe as outstanding because:

Incidents:

- There were systems in place to make sure incidents were reported and investigated. Staff had received training on incident reporting and risk management. Further details are outlined in the corresponding section of the surgery report.
- We saw examples in outpatients and diagnostic imaging where incidents had been recorded and investigated. Lessons had been learnt and shared with staff not only in the department concerned but across the hospital. For example, where the wrong limb had been X-rayed the investigation showed that the five point identification check had not been carried out. This checking process was reinforced to all staff. The lessons learnt were also shared across the hospital because of the relevance for all staff in checking they had the correct patient and were performing the correct procedure.
- During the reporting period from July 2015 to June 2016 there had been had two clinical incidents and 19 non-clinical incidents in the outpatient and diagnostic imaging department. Non-clinical incidents are all those incidents which did not involve patient care. The rate of non-clinical incidents was higher than the rate for other independent providers, however, it had been attributed to the failure of the MRI scanner on a number of occasions. These failures had not led to any clinical incidents but had increased waiting times whilst the scanner was out of action.
- Staff were aware of their responsibilities to report incidents and told us they had no hesitation in doing so. Staff told us they used the electronic incident reporting system. The incidents were then sent to the right manager for investigation and the feedback given to the staff who raised the incident. Staff confirmed that they did receive feedback from incidents they raised. Staff gave us examples of the incidents they had raised, these included breakdown in equipment, last minute staff sickness and cancelled appointments.

Duty of Candour:

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This regulation requires the hospital to be open and transparent when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds.
- Staff we spoke with could explain the principles of duty of candour and could give examples of when it had been used. For example, where an incident occurred in the diagnostic imaging department staff said the patient was kept informed and provided with explanations and apologies. We saw details of the resulting actions taken including telephone and written contact with the patient.
- Staff in outpatients and diagnostic imaging had 100% compliance with the training module.

Cleanliness, infection control and hygiene:

Outstanding ☆

Outpatients and diagnostic imaging

- There were systems in place to prevent and protect people from a healthcare-associated infection. Further details of the infection, prevention & control action plan for 2016 are outlined in the corresponding section of the surgery report.
- There had been no incidences of healthcare-associated infections in the 12 months before our inspection.
- The patients we spoke with were all complimentary about the cleanliness of the outpatient and diagnostic imaging departments.
- All the departments we visited looked visibly clean and tidy. We saw cleaning schedules for each room and department we visited. These showed that staff were signing off when the cleaning had been completed. The schedules showed all areas were cleaned consistently several times a day.
- There was an outbreak of Norovirus reported in April 2016; the first outbreak in over ten years since the centre opened. Further details of the actions taken are outlined in the corresponding section of the surgery report.
- The patient led assessment of the care environment (PLACE) scores from February 2016 to June 2016 showed the hospital scored 100% for cleanliness and 96% for site maintenance.
- Personal protective equipment (PPE) such as aprons and gloves were available for staff. We observed staff using PPE in accordance with hospital policy. Anti-bacterial hand gel was readily available in the outpatients, physiotherapy and diagnostic imaging departments. We observed staff washing their hands between patients and using hand gel.
- We saw green 'I am clean' labels placed on trolleys and equipment that had been cleaned and were ready for use.

Environment and equipment:

- Facilities and premises were designed in a way that kept people safe. Patients arrived at the main reception and were then directed to the waiting areas.
- The hospital had robust systems in place to make sure all equipment was checked, serviced and maintained according to manufacturer's recommendations.
- There was a corporate procurement programme, purchasing items from accredited and approved sources and this was supported by a facilities management programme of regular planned preventative maintenance and portable appliance testing (PAT). The layout of the outpatient and diagnostic imaging departments created an efficient flow and all areas were in good decorative order, and well maintained.
- The yearly external audit into the diagnostic imaging department confirmed that radiology equipment was maintained to a very high standard and subject to a comprehensive preventative maintenance programme of regular servicing.
- We saw up to date service records and a comprehensive fault log for the MRI scanner. We were told that the MRI scanner was coming to the end of its serviceable life and that the process had already started to obtain a new scanner for the department.
- Resuscitation equipment was stored on specialist trolleys that were secured with tamper proof tags. The equipment was checked regularly and we looked at the checklists which showed this was consistently carried out by staff and signed accordingly. Emergency medicines were checked and sealed by the pharmacy department.
- The diagnostic imaging department had arrangements in place to restrict access to the department. Patients were escorted into the department by a member of staff.

Medicines:

- There were systems, policies and processes in place for the safe storage, prescribing and administering of medicines. Details of the hospital's medicines management policy are outlined in the corresponding section of the surgery report.
- We looked at how medicines were stored within outpatients and diagnostic imaging and found they were stored in locked cupboards that only staff had access to. Some medicines needed to be stored in fridges, where this was the case, fridge temperatures had been checked on a daily basis to make sure the medicines were being stored at the correct temperature. We did not see any medicines that were out of date or stored incorrectly.
- Patients told us that staff provided them with information about their medicines and provided explanations in a way they could understand.

Records:

- Medical records were written and managed in a way that kept people safe.

Outpatients and diagnostic imaging

- A policy provided guidance to staff of their responsibilities in regards to the importance of safe, methodical and fully accessible storage of patient records and imaging films (hardcopy and /or digital) in line with national standards for an established period of time. Further details of the processes for the management of health records are outlined in the corresponding section of the surgery report
- The diagnostic imaging department used an independent radiology picture archiving and communication system (PACs), from which other providers could request image uploads through an image exchange portal. Patients benefitted from this system as GPs and other healthcare professionals could obtain images to guide treatment pathways.
- We saw evidence that showed monthly record keeping audits were completed within diagnostic imaging. Each audit reviewed 20 sets of records looking at whether the referral forms had been completed fully, if the radiation exposure was set correctly through to was it the correct patient and the correct area to be X-rayed or scanned. The results for July 2016 showed a 96% compliance rate which was above the 90% target set by the hospital.
- We spoke with the health records staff who told us that no patient was seen without their medical notes. When a new patient attended the hospital, their medical notes were put together prior to their first appointment and ready in outpatients when the patient attended. These notes were then available throughout their stay and returned to medical records when the patient was discharged. The notes were then filed on site or at secure off-site storage. If a patient had already been seen at the hospital before, their medical notes would be retrieved from filing ready for their next appointment. Staff told us that where necessary they could retrieve a patient's medical notes from off-site storage the same day.
- The hospital used an electronic patient record system in addition to the paper records. Staff had access to the electronic system to record what happened with each patient. As an example, a physiotherapist was able to see records documented by the ward staff and vice versa which meant all the staff were aware of the current needs of each patient. Referrals and diagnostic images were able to be viewed via the electronic patient record. In the event of a system failure, the paper records were always available.
- We checked five sets of paper medical records and five sets of electronic medical records. We found them to be complete and accurate, legible and up-to-date. We checked the electronic physiotherapy notes and found these to be accurate and up-to-date.

Safeguarding:

- There were systems, processes and practices in place to keep people safe. These had been communicated to staff. Details of the standard operating procedures, safeguarding lead arrangements, training and visitors' policy are outlined in the corresponding section of the surgery report.
- The staff we spoke with had a good awareness of the different types of abuse and how to report concerns.
- We saw how the teledermatology service had picked up a suspected case of abuse which otherwise might have been missed. This was referred back to the local referring GP and the local safeguarding board. The safeguarding lead within the hospital followed up with the GP to make sure safeguarding policies were followed.

Mandatory training:

- A key skill set document was available to all staff. This set out what courses were considered mandatory depending on their role. As an example, all staff were expected to complete the information governance training, whereas only certain clinical staff were expected to have advanced life support. Examples of mandatory training included safeguarding of adults and children, clinical governance, equality and diversity and health and safety. Further details of the training programme and monitoring processes are outlined in the corresponding section of the surgery report.
- We saw the training records that confirmed all the staff (100%) within outpatients, physiotherapy and diagnostic imaging had completed all their mandatory training against a the hospital target of 93%.
- The staff we spoke with confirmed they had completed all the required mandatory training, mostly via e-learning. Some staff told us they did not have enough time to do the training during their work time and would do it at home, however, they also told us they were paid overtime to do so.

Assessing and responding to patient risk:

Outpatients and diagnostic imaging

- Risk assessments were in place across outpatients, physiotherapy and the diagnostic imaging departments. We saw that these assessments were accessible to staff, were in date and had been reviewed regularly. The risk assessments covered issues from assessing patients on stairs within physiotherapy through to lone working within the diagnostic imaging department.
- The diagnostic imaging department had a service level agreement in place for the radiation protection advisor (RPA) to be provided by a hospital in London. We asked if this caused any problem in seeking advice when needed. Staff confirmed they had always been able to contact the RPA when they needed to and there were no examples of it ever being a problem.
- To monitor the quality of the X-rays being taken, regular quality assurance took place. Each month 10% of X-rays were peer checked to make sure the reporting was accurate.
- The diagnostic imaging department made sure that referral forms were completed correctly and made in accordance with Ionising Radiation (Medical Exposures) Regulations 2000 (IR(ME)R).
- Women of childbearing age were always asked about the possibility of their being pregnant prior to any radiological procedure taking place. If there was any doubt about a pregnancy, the radiographer would seek advice from the radiologist.
- The diagnostic imaging department was a secure department with entry via a swipe card system. Patients were called through from the waiting room to have their procedure. Signs were in place to highlight the radiation hazards within the department and when procedure rooms should not be entered whilst scans and X-rays were taking place.
- Systems were in place to transfer patients to the local acute NHS hospital if a patient became acutely unwell or needed more specialised care.
- Within the diagnostic imaging department radiation protective aprons were available and were checked regularly for wear and tear. Staff wore radiation exposure badges to monitor radiation exposure whilst working with the equipment.
- Not all of the main waiting area could be observed from the reception area, however, staff were constantly in and around the waiting area which meant patients and visitors were frequently observed.
- The hospital had a strict referral criteria in place which meant it only accepted non-emergency patients. Each referral was triaged by a nurse to make sure it met the criteria.

Nursing, physiotherapy and radiographer staffing:

- Staffing levels were sufficient to meet the patients' needs in the outpatients, physiotherapy and diagnostic imaging department.
- Within the diagnostic imaging department there were six whole time equivalent (WTE) radiographers and one WTE health care assistant (HCA) who was available to chaperone patients as necessary
- The diagnostic imaging department had a sickness rate of 0% since May 2016 which was within the hospitals target of less than 1%.
- At the time of our inspection there were 12.4 WTE nursing staff working within outpatients. Health care assistants provided a further 7.1 WTE bringing a total of 19.5 WTE staff.
- Agency staff were only used as a last resort, however, there was an active ongoing recruitment campaign for bank staff. This made sure bank staff got to know the departments and provided consistency for patients. We were told that it was normal to employ bank staff permanently when positions became available.
- Within the physiotherapy department there were three WTE physiotherapists and one WTE physiotherapy assistant. A bank physiotherapist was also available.

Medical staffing:

- Medical staffing levels were sufficient to meet the patients' needs within the outpatient department. At the time of our inspection there were 20 consultants employed by the hospital who worked within outpatients.
- However, there was only one radiologist within diagnostic imaging. The hospital had recognised that this was not sufficient and an advertisement had been placed for a sonographer to undertake ultrasound and free up some of the radiologist's time. We did not see any evidence to suggest the current staffing levels had any negative impact for patients. Staff told us that the recruitment of a sonographer would improve waiting times for patients.
- Arrangements were in place for radiologists at a local acute hospital to cover for annual leave and sickness on an ad-hoc basis.

Outstanding ☆

Outpatients and diagnostic imaging

Emergency awareness and training:

- The policies in place for business continuity are described in the corresponding section of the surgery report.
- Polices and plans were in place within diagnostic imaging in case of a radiation incident.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

The effectiveness of outpatients and diagnostic services was not rated due to insufficient data being available to rate these departments' effectiveness nationally. We found:

Evidence-based care and treatment:

- Policies and guidelines had been developed in line with national guidance. These included the National Institute for Health and Care Excellence (NICE) and the policies were available to all staff via the intranet system and staff demonstrated they knew how to access them.
- The diagnostic imaging department used diagnostic reference levels (DRLs) as an aid to optimisation of medical exposures to keep patients safe. These levels were used to help staff make sure the right amount of radiation was used to image each part of the body. Staff were able to locate and explain how they used DRLs to make sure that staff used the correct amount of radiation to image each part of the body.
- The diagnostic imaging department was audited yearly by their radiation protection advisor. The audit looked at compliance with national Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000 and health and safety guidance. Audits covered quality of image, positioning, dosage and markers. Learning was shared with individuals as well as broader lessons shared across the department. We looked at the report from the last audit in January 2016. This showed a high level of compliance with four areas for improvement.
- All patient referrals to the diagnostic imaging department were made by registered healthcare professionals as defined under IR(ME)R 2000, and clear referral criteria was in place, including for non-medical referrers, such as osteopaths.

Pain relief

- Staff said it was unusual to have to ask patients in outpatient clinics to rate their pain although all staff demonstrated a good understanding of simple comfort scale methods available to them for the management of patient's pain.

Nutrition and hydration:

- During our inspection we saw water was available in the waiting areas for outpatients, physiotherapy and diagnostic imaging. A café was also available for patients and visitors serving a variety of food and beverages.

Patient outcomes:

- Information about the outcomes of people's care and treatment was routinely collected and monitored.
- A number of regular audits were carried out to monitor performance against national patient outcomes and to maintain standards. Further details of the action plans, monitoring process and audit schedule are outlined in the corresponding section of the surgery report.
- Due to a national shortage of dermatology consultants, the hospital was asked by commissioners to provide a dermatology service on a test-and-learn basis. In 2014 the hospital established the 'teledermatology' service. This service allows GPs to take photographs of a patient's skin problem and have them reviewed by a dermatologist. The dermatologist then determined whether more information was required, what treatment the GP should initiate, and whether the patient should be referred onto the hospital for the two week suspected cancer pathway. Staff told us it was proposed to roll out the service to GP practices across Somerset in the next six to eight months following our inspection.
- Since the 'teledermatology' service started the quarterly referrals had risen from 26 (October to December 2014) to 221 (January to March 2016). Out of a total of 872 referrals, only 169 (26%) were referred onto the local dermatology service at the acute NHS hospital. This meant that a large proportion of patients could be treated by their GP without the need to attend the acute hospital.
- The physiotherapy department maintained a database to track the progress of its patients including any complications they might have experienced. This meant

they were able to tailor the rehabilitation programmes to the needs of each patient. Where a physiotherapist had a concern, they were able to refer the patient back to see the consultant.

- The physiotherapy team had established a falls prevention programme which included six structured sessions led by the physiotherapists. Each session lasted one and a half hours and consisted of exercises, clinical assessments and general discussions on falls prevention. The programme had been audited since starting in 2014 and had shown positive results in the falls risk scores. Patients who had been through the programme were shown to have lower scores than those patients who had not been through the programme. This meant they were less likely to have a fall. The audit also showed that when the programme started 70 patients suffered a fall within a year of their joint replacement surgery, by 2016 this had reduced to 46 despite the increase in the number of patients being seen.
- The physiotherapy team arranged to see patients who had knee replacements three weeks following their operation. This allowed the staff to identify patients who were not doing as well as expected which meant they could change their treatment programmes to suit that individual patient. This showed a marked improvement by the time the patient saw the consultant six weeks after their operation. We saw emails from consultants complimenting the physiotherapy team because they had seen a drop in patients attending their six week clinic with stiff knees.

Competent staff:

- The hospital had systems in place to monitor the registrations of qualified staff such as nurses, physiotherapists and radiographers. This made sure that no member of staff was practising without their professional registration.
- The hospital had competency frameworks in place for staff. This meant that staff were trained and assessed to perform various tasks safely. For example, staff were assessed on their ability to communicate effectively with patients through to operating specialist pieces of equipment. Staff were able to self-assess themselves initially and then be assessed by their manager and signed off as competent or recommended to receive additional training.
- Staff had the right skills, knowledge and experience to do their job. These were regularly reviewed through the appraisal system. Staff told us that there were lots of opportunities to do additional training and felt very supported by the hospital. One member of staff told us “this is the first time I have worked for a company who will allow you to develop and attend training courses.”
- We saw evidence to show that staff within outpatients, physiotherapy and diagnostic imaging had been trained to undertake their role. For example staff within diagnostic imaging had been trained to safely administer radiation.
- Details of the generic clinical competencies and learning management system are outlined in the corresponding section of the surgery report.
- Each member of staff within outpatients, physiotherapy and diagnostic imaging had received their appraisals and regular reviews.

Multidisciplinary working:

- The staff we spoke with felt that there was good multidisciplinary working across all the departments in the hospital and with other healthcare providers. All staff worked together to assess and plan ongoing care and treatment in a timely way. This included when people were due to move between teams or services.
- We saw minutes of meetings that showed effective working between teams and good representation from different professionals.

Seven day service:

- The hospital operated a six day outpatient service, Monday to Saturday, from 7.15am to 9pm.
- In diagnostic imaging, scans, X-rays and ultrasounds were available Monday to Saturday between 9am and 5pm. A 24-hour on call rota was in place to provide emergency cover for inpatients.
- All pharmacy services were available Monday to Friday between 8.30am and 4.30pm.
- The physiotherapy provided a service for both in-patients and outpatients Monday to Friday 9am to 5pm. Outside of these hours, an on-call service was provided to inpatients only.

Access to information:

- The information needed to deliver effective care and treatment was always available in either paper based records, electronic patient records or both.

- Within physiotherapy, a summary of all the patients seen the previous day was available for handover in the morning. This detailed the treatments each patient was having and their progress. This allowed the physiotherapy team to provide continuity of care and treatment to their patients.
- Staff confirmed records were provided quickly and there was good and quick access to test results and diagnostic and screening tests.
- Standard operating procedures were in place to assure patient confidentiality was maintained at all times within the hospital.

Consent, Mental Capacity Act and DOLS:

- The staff we spoke with were aware of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) although they had not had to put it into practice. Staff had attended mandatory training and knew what their responsibilities were and how to apply them within everyday practice when required.
- Staff told us that if they had concerns over a patient's capacity to make decisions they would seek advice from their manager, consultant and the hospital's policy.
- Staff told us about situations where patients had been seen but relatives had held the power of attorney. In these cases the staff always asked to see the original copy to confirm a relative's position. Staff were also aware of the best interests' checklist that could be used when necessary.
- We saw evidence within diagnostic imaging where written consent was taken. For example when a patient needed a scan using contrast (a dye injected into the body that is visible on X-ray / scans). We also saw examples in the outpatient department of staff asking verbally for a patient's consent before providing any care. The physiotherapy staff told us they always sought the patient's consent before starting any treatment. This was documented on their electronic records and the records we looked at confirmed this.

Are outpatients and diagnostic imaging services caring?

Outstanding ☆

We rated caring as outstanding because:.

Compassionate care:

- Patients were treated with kindness, dignity, respect and compassion whilst they received care and treatment.
- Feedback from patients who used the service and those who were close to them were continually positive. The patient satisfaction scores showed consistently high satisfaction rates. From October 2015 to September 2016 99.2% of patients surveyed said they would recommend the service at the hospital to their friends and family if they needed similar care or treatment. All patients attending the physiotherapy department said that they would recommend the department to others.
- The patients we spoke with during our inspection were very positive about their care and treatment. Comments included: "the staff are lovely"; "I choose to come here because of the shorter waiting times, but I am so glad I did, the staff are brilliant and I feel well looked after"; "it's very pleasant here, my GP recommended it and so far I have no complaints"; "a nice environment and great staff, overall I have had a very positive experience"; "the service has been excellent … much better than I thought," "the staff are so kind and nothing is too much trouble."
- Patients told us, and we saw without exception the staff were friendly, kind and approachable. One patient said,"It is the staff that make a difference here."
- All patients were greeted in a friendly manner by all the staff they came in contact with. We heard all healthcare professionals introducing themselves when dealing with patients and relatives and explaining their roles and responsibilities.
- Patients and their relatives were hugely complementary about staff, saying they always had time to listen and give support and encouragement to patients. Patients told us staff never seemed rushed .
- Throughout our inspection we observed patients being treated with the highest levels of dignity and respect. In the outpatients department, consultation room doors were kept closed when the patients were seeing the doctors or nurses. Staff always knocked before entering a room. Within diagnostic imaging, private changing rooms were available where patients could change ready for their specific procedure.
- Patients were asked if they wanted a chaperone, and one was provided when necessary. Signs were also displayed in the waiting areas informing patients that chaperones were available.

Outstanding ☆

Outpatients and diagnostic imaging

- Patient's waiting for their outpatient or diagnostic imaging appointment were collected from the main waiting areas by a member of staff and personally escorted to the correct room.
- Staff asked what patients would prefer to be called and then addressed them accordingly.
- Staff behaved positively to provide the best possible care for their patients. It was evident the patient experience was a central element to the delivery of care. Care from the nursing, medical staff and support staff was delivered with kindness and patience. The atmosphere was calm and professional without losing warmth and reassurance.
- We observed numerous respectful and compassionate interactions between staff and patients and those close to them, with staff treating each patient as an individual and making time to talk with them. Staff were open, friendly and approachable but always remained professional.
- We spoke to several staff who had themselves received treatment at the hospital. They told us that it "speaks volumes that I would choose to be treated here and I would be happy for my family to be treated here too".

Understanding and involvement of patents and those close to them:

- Patients who used the service and those close to them were involved as partners in their care. Patients and relatives were encouraged to be involved in their care as much as they felt able to.
- Patients reported staff going out of their way to find out information for them; explaining everything clearly,listening and answering questions. They said they were fully involved in decisions about their care and treatment and knew how to access advice.
- Patients said staff shared as much or as little information with them as they wanted. A patient told us "the staff are unbelievable in always making time to talk to me, giving all the time I need – I don't have a single concern".
- Staff recognised when patients needed additional support to help them understand and be involved in their care and treatment. We observed staff taking time to explain things to patients in a way they could understand. For example, during a complex explanation, time was allowed for the patient or their relative to ask whatever questions they wanted to.
- We saw examples of where staff understood the needs of their patients. Within diagnostic imaging staff went to great lengths to ensure the patient, who had a disability, was as comfortable as possible by using additional support with pillows and reassuring them that there was no rush and they would proceed at the pace to suit the patient.
- One patient told us that they needed to arrange their admission date so that their relative could take time off work to help look after them once they got home. The patient told us how accommodating the hospital was in offering several different dates for them to be admitted.

Emotional support:

- Patients and those close to them received the support they needed to cope emotionally with their care, treatment or condition.
- Staff understood and demonstrated an understanding of the impact that a person's care, treatment or condition would have on their wellbeing and on those close to them, both emotionally and socially. We observed staff providing emotional support to patients and relatives during their visit. We saw anxious patients being allowed extra time to resolve and relieve their individual concerns, and staff were reassuring and knowledgeable.
- Data from patient experience audits showed within the physiotherapy department, 100% of patients said they felt involved in their treatment programmes. The data also showed a total of 96% of patients in the outpatients department said they knew who to talk to if they had any worries following discharge.
- Care Quality Commission comment cards were left in the outpatients department before, during and after our inspection. The comments made by patients included "good service", "really fast and informative", "everybody is friendly". Another positive comment included "The staff are always warm and welcoming from the receptionist to the medical professionals. I have always been treated with the greatest respect and had first class treatment. The staff are kind, caring and eager to help. I would give it five stars if it were a hotel. Whenever my partner or I have a medical need we always choose Shepton Mallet. Well done everyone. Excellent."
- During a comprehensive preoperative assessment we saw a patient being given detailed advice about what to do at home prior to the day of their surgery. This included what to eat and drink, and what to bring in to

hospital. The patient was also given advice about what to expect during their stay and after discharge. The patient raised concerns about using the equipment, and was reassured by the member of staff that they would not be discharged until they were able to use all the equipment confidently. Opportunity for patients to ask any questions or raise any concerns was also observed during the assessment. Staff responded in a reassuring and knowledgeable manner and the patient told us they felt "so much more relaxed about the whole thing … and I know I can phone if I need to go over what to do again."

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good because:

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

- Information about the needs of the local population was used to inform how services were planned and delivered.
- The outpatient and diagnostic imaging departments were patient centred with a television, magazines and water dispensers available. Facilities for children were limited; however, because the hospital did not see or treat anyone under the age of 18 years, the only children present would be accompanying their parents.
- All areas of the treatment centre were accessible to wheelchair users. Portable hearing loops were available at the main reception desk and could be carried around the treatment centre as required.
- There was sufficient free car parking for patients attending the hospital. A free transport service was also provided to patients in the more rural communities where public transport was sporadic. Further details of the service are outlined in the corresponding section of the surgery report.

Access and flow:

- The hospital had systems in place to make sure referrals were received and provided with appointments in a timely way.
- The hospital had produced a referral guide for local GPs and other NHS providers. This set out the services that could be provided and the procedures performed. Exclusion criteria was explained to avoid unsuitable referrals. These included no referrals for people under 18 years of age or who had a known reaction to anaesthetic.
- Referrals came into the booking office via paper and electronic means and were triaged to make sure the referral followed the criteria. Once accepted, the patient was telephoned to arrange a convenient outpatient appointment and a confirmation letter was sent out. Patients could access care and treatment with a choice of appointments being offered when required.
- Waiting times for diagnostic imaging ranged from one to two days for plain X-rays through to two weeks for ultrasound and MRI scans. Reports were sent out within seven days via e-mail and posted directly to the patients' GP. Where an urgent report was required, the hospital could fax it directly to the GP.
- The hospital operated one stop clinics for those patients who might require surgery. This meant that once they had seen the consultant and surgery had been agreed, the nursing staff would perform the additional tests needed such as blood tests or screening so that the patient was ready to have their operation without the need for further outpatient attendances.
- The hospital worked to a 10 week contractural pathway, and had introduced a referral management page to the electronic patient record, to improve the capture of data during the patient episode. This enabled the hospital to populate a weekly wait time report, which was published on the hospital's web site, and to the Referral Management Centre. In addition to this, the local booking team received a weekly speciality specific waitiing times report to ensure that patients were booked in breach order. As a response to any increase in wait times, and as part of the weekly capacity planning meetings, the hospital reviewed the current schedule to see if they were are able to add any additional activity within that speciality, with the specific purpose of reducing the wait time.
- From July 2015 to July 2016 the department saw 24,517 for consultant and nurse led clinics and pre-operative assessments. During the reporting period the outpatient department met the 92% target of patients being treated within the pathway and was above the 95% target for patients starting non-admitted treatment.

Outstanding ☆

Outpatients and diagnostic imaging

- During our visit we saw that once patients arrived in the department they were seen promptly and if clinics were running late staff informed them on arrival and regularly checked with patients in the waiting room. However, data from July 2015 to June 2016 showed the average waiting time for patients attending their first appointment with a consultant was 25 minutes. The data also showed out of a total of 7,775 first appointments there were 723 patients who had waited for longer than an hour in the department.
- Patients were advised that chaperones were available to support them at any time during their appointment and were advised to ask a member of the nursing team.
- Care and treatment was only cancelled or delayed when absolutely necessary. Patients told us that cancellations were always explained to them, and they were supported to access care and treatment again as soon as possible.

Meeting people's individual needs:

- Services were planned to take into account the needs of different people.
- Staff recognised the need for supporting people with complex or additional needs such as people living with dementia or a learning disability. The hospital consistently planned services and delivered and coordinated them to take account of people with complex needs. For example, the outpatient and diagnostic imaging services arranged appointments so that new patients were allowed time to ask questions and have follow-up tests.
- Pre-operative assessments were conducted to determine if a patient was physically fit enough to have surgery and an anaesthetic.
- For those patients whose first language was not English, an interpreting service was available. The staff we spoke with were aware of the service and how to access an interpreter when it was required. However, there were occasions when this best practice was not used, for example staff told us that where an interpreter was not available or where the patient specifically wanted it, an adult relative was used to interpret and very occasionally a member of staff if they spoke the same language. Staff said that where consent for a procedure was being discussed, an interpreter was always used.
- Staff told us that occasionally patients were given the wrong date for their appointment. When this happened, apologies would be given but the patient was never turned away. They were given the option to stay and wait to be seen or another appointment would be made for them.
- The physiotherapy department had been extensively involved in the development of a specialised computer application to run on mobile phones and computer tablets. The application was called 'pocket physio' and when the application was launched five years ago, the department won an innovation award for it. This application allowed patients to physically view the exercises they needed to do.
- We saw that a wide variety of written information about conditions and treatments was available in the outpatient department. However, some staff were not aware if this information was available in other formats such as large print or different languages.

Learning from complaints and concerns:

- The hospital had a complaints process in place that made sure any complaint was investigated thoroughly. Details of the process to appropriately investigate, monitor and evaluate patient's complaints are outlined in the corresponding section of the surgery report.
- We saw evidence of where staff had learnt from complaints. For example within diagnostic imaging a complaint was received regarding a member of staff. Following investigation an action plan was created and additional specific training was provided to the member of staff.
- Patients we spoke with told us they knew how to make a complaint or concern but had not felt the need to do so. Staff told us that they would try and do everything they could to address a concern or complaint at the time and if they were unsuccessful they would escalate it to their managers or the complaints lead.

Are outpatients and diagnostic imaging services well-led?

Outstanding ☆

We rated well-led as outstanding because:

Leadership culture of service related to this core service:

Outstanding ☆

Outpatients and diagnostic imaging

- The leadership and culture of the outpatient and diagnostic imaging departments reflected the vision and values of the hospital and encouraged openness, transparency and promoted good quality care. The local leadership had the skills, knowledge and integrity to lead the teams.
- The staff we spoke with during our inspection told us they were very proud to work for the hospital, but felt part of the hospital rather than the wider Care UK organisation.
- All the staff we spoke with gave praise about their immediate line manager and the senior management team. They told us that the managers were visible and approachable, although some staff told us that the senior managers had not been as visible recently as they had been. The senior managers acknowledged this and told us they had not been as visible because of the work involved in preparing the bid for extending the hospital's services.
- Staff told us that the hospital was a friendly place to work where everyone knew each other. They told us that it was an open place to work and that there was no blame culture when things did not go as planned.
- Staff told us they felt respected and valued by their immediate managers and the senior management team. Staff felt listened to and were encouraged to share their feedback.
- Staff said they were encouraged to raise concerns. They were aware of the whistleblowing policy and the arrangements for reporting poor practice without fear of reprisal. They felt comfortable and confident about raising concerns.

Vision and strategy for this service:

- The hospital had a clear vision and strategy to deliver good quality care to patients.
- Details of the vision and strategic objectives for the coming year are outlined in the corresponding section of the surgery report.
- The outpatient and diagnostic imaging departments had developed their own visual strategic objectives which outlined the quality and business objectives for the next year. They were reviewed as part of their monthly departmental meetings.
- Outpatient objectives included dementia screening, reducing clinical cancellations, developing a mentorship programme, growing the service, developing a treatment room for minor procedures and refining labour management to reflect increased capacity at satellite clinics.
- In diagnostic imaging, objectives included the embedding of core clinical competencies, appointing a sonographer, developing the clinical leadership role of the deputy manager, developing extended hours, reviewing radiology reporting, replacing the MRI scanner, increasing MRI volumes and reviewing existing business systems.
- Physiotherapy objectives included the development of a workforce training programme, consistently achieving high day zero mobilisation, achieving a reduction on cost of consumables, expanding and improving the falls prevention service, effectively and efficiently using the internal audit plan, facilitating the use of technology in rehabilitation and working on shoulder protocols to update the pocket application.
- The staff we spoke with were aware of the strategy for their own departments and for the hospital as a whole.
- Staff were also aware of the values of the hospital and explained they were integrated into their staff performance review. These values included: "Every one of us makes a difference", "Customers are at the heart of everything we do" and "Together we make things better."

Governance, risk management and quality measurement:

- There was an effective governance framework in place to support high quality patient care. Further details are outlined in the corresponding section of the surgery report.
- Staff told us that everyone was encouraged to get involved with governance because it was everyone's responsibility.
- At the time of our inspection, the diagnostic imaging department was working towards accreditation in the Imaging Service Accreditation Scheme (ISAS). This was a patient focused assessment and accreditation programme and used to help make sure high quality service was consistently delivered to patients. This meant the department wanted to strive for excellence for its patients.

Public and staff engagement:

Outstanding ☆

Outpatients and diagnostic imaging

- The hospital had systems in place to effectively engage with patients, visitors and staff.
- There were a variety of methods for patients and visitors to leave their feedback and signs were visible in all the departments we visited to highlight these to patients. Methods of feedback included speaking to staff, completing satisfaction surveys, leaving a review via the main NHS website, using portable computer tablets available in each department or writing to or emailing the hospital.
- The hospital sought input from the patient forum group regarding elements of the patient experience and discussed service developments and improvements with previous service users. Further details of the forum are outlined in the corresponding section of the surgery report.
- The patient satisfaction feedback for the outpatients, physiotherapy and diagnostic imaging departments was consistently very high. The staff were very proud of the satisfaction scores and worked hard to maintain them by providing first class quality care.
- Details of the results from the 2016 staff survey are outlined in the staff engagement section of the surgery report.

Innovation, improvement and sustainability:

- Staff were clear that their focus was on improving the quality of care for patients. They felt there was scope to develop services and a willingness amongst the team to continually improve.

Outstanding practice and areas for improvement

Outstanding practice

- There were strong, comprehensive and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse.
- Patients had excellent outcomes and their care and treatment was planned and delivered in line with evidence-based guidance, standards and best practice.
- The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care. Staff had the skills required to carry out their roles effectively and were proactively supported to maintain and develop their professional skills and experience.
- There was outstanding care provided to the patients. Patients were respected and valued as individuals and were empowered as partners in their care. Patients were highly satisfied with the care they received and we observed this in practice.
- There had been a number of outstanding service developments. These included the teledermatology service which had reduced the amount of unnecessary referrals to the NHS acute hospital dermatology departments meaning patients could be treated in their own home by their GP.
- Other developments related to the falls prevention programme which had shown positive results in the reduction of falls; and the specialised computer application to run on mobile phones and computer tablets which enabled patients to physically view the exercises they needed to do.
- There were comprehensive governance arrangements in place which allowed the hospital to work in line with best practice and deliver high quality care. Patient care was at the centre of everything they did.
- Frontline staff and senior managers were passionate about providing a high quality service for patients with a continual drive to improve the delivery of care.
- There was excellent local leadership of the services. The senior management team had an inspiring shared purpose and were committed to the patients who used the services, and also to their staff and each other.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should develop an action plan to reorganise the store room in theatre.
- The provider should reduce the average waiting time for patients attending their first outpatient appointment with a consultant.
- The provider should strengthen staff awareness of how to access information in different formats/languages, and to follow best practice by not using relatives to translate.