Circle Health Group Limited

The Chaucer Hospital

Inspection report

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

Ratings

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

Summary of findings

Overall summary

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

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. People could access the service when they needed it and did not have to wait too long for treatment.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Not all surgical patient assessments showed completed fluid balance charts.
- Patient safety information was not always complete in MRI referral forms.
- The x-ray door was not always locked when radiation was in use.
- The MRI scanner had a significant layer of dust on it.
- Patient areas did not always display information on how to raise a complaint.

We rated this service as good because it was safe, effective, caring, responsive and well-led. We currently do not rate effective in outpatients and diagnostic imaging services.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Our rating of this service stayed the same. We rated it as good because: • The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. • Staff provided good care and treatment, gave patients enough to eat and drink and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and made sure that they had access to good information. Key services were available seven days a week. • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. • The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait long for treatment. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and

Summary of findings

accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to continually improving services.

However:

- We found that not all patients' assessments showed completed fluid balance charts.

We rated this service as good because it was safe, effective, caring and responsive, although leadership requires improvement.

Outpatients

Good

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

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available five days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt

Summary of findings

respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Not all staff were aware of the hospital's top risks.

We rated this service as good because it was safe, effective, caring, responsive, and well led.

Diagnostic imaging

Good

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

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to drink. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and had access to good information. Key services were available to suit patients' needs.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were

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However:

- Patient safety information was not always complete in MRI referral forms.
- The x-ray door was not always locked when radiation was in use.
- The MRI scanner had a significant layer of dust on it.
- Patient areas did not always display information on how to raise a complaint.

We rated this service as good because it was safe, effective, caring, responsive and well-led.

Medical care (Including older people's care)

Good

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

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

Summary of findings

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

Medicine is a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.
We rated this service as good because it was safe, effective, caring, responsive, and well led.

Summary of findings

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Summary of this inspection

Background to The Chaucer Hospital

The Chaucer Hospital is operated by Circle Health Group. BMI Healthcare joined Circle Health Group in January 2020. BMI The Chaucer Hospital is now The Chaucer Hospital. It is a private hospital located in Canterbury, Kent. The hospital primarily serves the communities of Canterbury, Faversham and Dover. It also accepts patient referrals from outside these areas.

The Chaucer Hospital provides surgery, endoscopy, medical care including oncology, outpatients and diagnostic imaging services to people over the age of 18. Specialties include orthopaedic, gynaecology, urology, gastroenterology, ophthalmology, and cosmetic surgery. Care and treatment are provided to NHS patients and people who have private medical insurance and who self fund.

The hospital has 55 beds with en-suites spread over two wards. Facilities include two main theatres, an accredited endoscopy suite, an accredited oncology suite, outpatients with one minor procedure room and diagnostic facilities. The hospital has MRI, CT, ultrasound, X-ray and digital mammography within its imaging department. There are no emergency facilities at this hospital.

The hospital also offers services such as physiotherapy, an on-site pharmacy, a restaurant and WIFI.

The hospital is registered to provide the following regulated activities:

• Treatment of disease, disorder or injury

• Surgical procedures

• Diagnostics and screening procedures.

The hospital has a registered manager who has been in this post since September 2019. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage a service. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how a service is managed.

The hospital was previously inspected in 2016 and it was rated as good.

We inspected The Chaucer Hospital using our comprehensive inspection methodology. We carried out a short notice announced inspection on 22 February 2022.

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

How we carried out this inspection

During the inspection visit, the inspection team:

Summary of this inspection

- assessed and visited the diagnostic imaging service, reception and outpatient areas, endoscopy suite, oncology unit, the wards, theatres, day surgery and recovery area.
- reviewed the overall governance processes for the hospital and reported this as part of the well-led domain.
- spoke with 55 members of staff including senior leaders, managers, doctors, nurses, allied health professionals and support staff.
- spoke with nine patients and two relatives and carers.
- observed patient care and procedures with their consent, looked at patient waiting areas and clinical environments, and attended staff meetings.
- reviewed 27 patient care and treatment records, six incident investigations and 10 complaint responses
- looked at a range of hospital policies, procedures and other documents relating to the running of the services.

After the inspection visit, the inspection team:

- carried out virtual interviews with senior members of staff.
- reviewed further service information such as performance, training compliance, audits, policies and feedback from stakeholders including patients.

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

Outstanding practice

Outpatients:

- Staff truly embraced the service's patient safety focus where all staff were able to 'stop the line' to prevent a risk to patient safety. The team immediately discussed the issue to reduce the risk of harm to patients before incidents occurred.

Areas for improvement

We told the service that it should take action because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

Surgery:

- The service should ensure that all fluid balance charts are fully completed (Regulation 12).

Summary of this inspection

Diagnostic Imaging:

- The service should ensure that relevant patient safety information is completed in patient referral forms (Regulation 12).
- The service should ensure staff follow the local policy to lock the x-ray door when radiation is in use (Regulation 12).
- The service should ensure all areas are clean and dust free (Regulation 15).
- The service should ensure they display information about how to make a complaint in patient areas (Regulation 16).

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are Surgery safe?

Good

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

Mandatory training

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

The mandatory training was comprehensive and met the needs of patients and staff. The hospital had a clear mandatory training programme and included training such as health and safety, infection prevention and control (IPC), information governance, fire safety, equality and diversity, manual handling and basic life support. All staff within the surgical ward, theatre and recovery had met the target rate of 90% for completion in all mandatory training subjects.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff were clear on how to access their training through e-learning modules and face to face training. Staff told us they found it difficult to complete training on the ward due to the lack of computers. However, staff were able to access training records from home to complete their mandatory training and they were paid for the time it took to complete this online training.

Nursing staff received and kept up to date with their mandatory training. Staff completed training relevant to their individual needs and relevant to their role. The mandatory training programme included training on aseptic non-touch technique and care and communication of the deteriorating patient.

All staff within the ward, recovery and theatres had immediate life support training, with four staff completing advanced life support training. Another two staff within theatres and recovery were due to complete advanced life support training.

Medical staff received and kept up to date with their mandatory training. Consultants completed mandatory training in the NHS hospitals they worked within, as part of their appraisal process.

There were two resident medical officers (RMO) based within the hospital. At the time of the inspection they were both not working and there was an agency RMO in place.

All RMOs were up to date with their mandatory training and the agency RMO had completed their mandatory training through the agency they were employed with.

Good

Surgery

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff were 100% compliant with their training.

Safeguarding

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

Safeguarding policies provided staff with guidance on how to identify abuse and the processes to follow to raise a safeguarding concern.

The hospital followed the national core skills framework for safeguarding training.

There was an up to date corporate adult safeguarding policy as well as a children and young people's safeguarding policy. Policies incorporated mental health capacity, deprivation of liberty safeguards, female genital mutilation, sexual exploitation and PREVENT training. PREVENT training aims to safeguard vulnerable people from being radicalised to supporting terrorism.

Safeguarding training updates were required every two years and all staff were up to date. Staff were 100% compliant in safeguarding vulnerable adult's level 1 and 2 as well as 100% compliant in Safeguarding children level 1 and 2. However, the hospital no longer provided surgery to children and young people under the age of 18 years.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff demonstrated a clear understanding of safeguarding responsibilities and safeguarding procedures. Staff knew who the safeguarding lead was for the hospital and felt they were able to gain advice and support if needed.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. We were given an example of how the service would provide support to patients they found to be vulnerable during pre-assessment. A best interest meeting would take place for all patients identified as needing further support.

The patient and their family would be part of the meeting alongside the consultant, nursing staff and safeguarding lead to put together a plan of support pre and post-surgery for the patient.

We saw safeguarding posters and flowcharts displayed on notice boards in the surgery service. These gave staff a clear and concise visual reminder about the process they should follow if they had a safeguarding concern.

Staff had Disclosure and Barring Service (DBS) checks completed before they could work at the hospital. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

The hospital safeguarding lead was trained to level three and they had access to a regional safeguarding lead trained to level four.

Quarterly safeguarding meetings took place for London and South East hospitals within the corporate group. We saw evidence of these meetings through meeting minutes. Actions were discussed, tracked and incidents shared across the teams for learning.

Good

Surgery

Cleanliness, infection control and hygiene

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

The hospital had infection control policies and procedures to help control infection risk. These and other related policies covered the actions required by staff to minimise the risk of infection and cross infection in the hospital and the surgery service.

Protocols and procedures were in place in response to the COVID-19 pandemic. The hospital followed NHS and government guidance around best practice infection prevention and control measures for healthcare settings. The protocol included information for when staff, patients and visitors arrived at the hospital and for patients who needed to isolate and were required to have a negative COVID-19 test prior to their elective surgery.

On entry all patients and visitors were asked to wear a medical face mask (masks were provided) and complete a declaration form relating to their current health to detect any signs or symptoms of COVID-19. Alcohol based gel was available at the front entrance of the hospital and all people entering were asked to use it.

Visitors were not allowed onto the hospital site unless this had been previously agreed by the consulting team or for the purpose only of supporting a vulnerable patient. All visitors on the hospital site followed the same isolation procedures as the patient.

Hand sanitising gel was available throughout the hospital and we saw staff use this. We saw signs throughout the ward and theatres which reminded patients and staff of the need for social distancing to reduce the spread of COVID-19. There were signs showing how many people were allowed into a room at one time to minimise overcrowding.

Posters highlighting the importance of good hand hygiene were on display around the surgical ward areas.

Staff followed infection control principles including the use of personal protective equipment. Staff followed the infection control precaution policy well including the use of personal protective equipment. Staff adhered to the infection control policy and all staff were bare below the elbows and wearing the correct uniform. All staff wore medical face masks or protective visors throughout the surgical areas at all times. Staff were seen putting on and taking off aprons correctly.

Staff completed hand hygiene audits to monitor compliance every other month. Records showed theatre and inpatient ward staff had achieved 100% compliance over the last three audits.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

All surgical areas including wards, theatres and recovery were visibly clean and tidy. Following our previous inspection all patient rooms now had dedicated hand wash basins in accordance with the *Department of Health Building Note 00-09: infection control in the built environment.*

The service performed well for cleanliness. The hospital had housekeeping staff who were responsible for cleaning patient and public areas, in accordance with daily and weekly checklists. Cleaning records were up-to-date and showed areas were cleaned regularly and deep cleaned when needed.

Good

Surgery

Cleaning audits were completed monthly. Compliance for cleaning audits were between 90% and 100%. All surgery inpatient wards and theatre areas were compliant in all areas of the clinical audit.

The IPC lead was visible within theatres and inpatient areas. Staff told us they were able to request support and advice when needed and received regular IPC updates. The IPC lead would complete spot checks to make sure staff were compliant.

Staff were required to complete IPC training during their induction and then yearly. Clinical and non-clinical staff within the surgery service were 100% compliant with infection prevention and control training.

The hospital had two operating theatres one of which had laminar flow theatre ventilation. Laminar flow theatre ventilation is a system that circulates filtered air to reduce the risk of airborne contamination. Laminar flow works to prevent airborne bacteria from getting into open wounds. It also works to remove and reduce levels of bacteria on exposed surgical instruments.

Staff followed good practice guidance and maintained clean and dirty flow within the operating theatres. This included limiting the number of staff entering the operating theatre during surgery and restricting the movement of personnel in the operating theatre to a minimum.

The hospital had a sterile services quality and management systems manual. The decontamination and sterilisation of surgical instruments took place offsite.

Staff worked effectively to prevent, identify and treat surgical site infections. The hospital had recorded one surgical site infection between February 2021 to January 2022.

Nursing staff carried out infection control risk assessments on all patients as part of their pre-admission assessment process. This included details about any recent illnesses; Methicillin resistant staphylococcus aureus (MRSA) status and possible exposure to MRSA or infectious diseases in the month prior to pre-admission screening. This facilitated the identification of infection risks at the earliest possible time in the patient's care pathway to make sure correct infection prevention and control practices were put in place.

The hospital had no reported incidences of C. difficile, methicillin sensitive staphylococcus aureus and MRSA between February 2021 to January 2022.

Environment and equipment

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

The design of the environment followed national guidance. The surgery service had suitable facilities to meet the needs of patients for the type of care delivered. There were two theatres, one with a laminar flow system, three recovery bays and two anaesthetic rooms. Each of the designated areas had the required equipment. There was a logbook kept with each anaesthetic machine to record the daily pre-session check and these had been completed, as recommended by the Association of Anaesthetists of Great Britain and Ireland.

Good

Surgery

Single use sterile instruments were stored appropriately and were within date. The theatre equipment store had sufficient storage space and items such as surgical procedure packs and implants. Consumable items were appropriately stored off the floor on racks, in a tidy and organised manner.

The hospital had a tracking system for details of specific implants and prothesis to be recorded and reported to the national joint registry.

We saw that all equipment was tracked and traced. All records that we looked at had clear evidence of this with batch numbers recorded.

The hospital used a track and trace system to trace all reusable equipment and instruments to make sure appropriate maintenance, correct decontamination and traceability to associated patients. Theatre Sterile Supply Unit was offsite and based within a corporate hub to ensure compliance with regulatory requirements for decontamination, *Health Technical Memorandum 01-01: management and decontamination of surgical instruments (medical devices) used in acute care*.

Theatres had a designated healthcare assistant (HCA) who had taken responsibility to develop a system which was overseen by the clinical services theatre manager to keep a clear account of equipment and instruments. This included all loan equipment sourced from external companies.

The process devised was comprehensive and we were told that the system worked smoothly, and we saw clear documentation of current equipment in and out of theatres. The HCA showed a good understanding of the cleaning and maintenance of items in theatres and this gave us assurance equipment checks within theatres were completed daily.

The hospital had two wards. Cornwallis ward is an inpatient ward for surgical and some day case patients. Mountbatten is a day case ward.

Cornwallis ward had 25 rooms all of which were ensuite. Patients could reach call bells and staff responded quickly when called. Each patient room and bathroom had emergency call bells which were easily accessible to patients. Suction and piped oxygen was available in each room.

The service had suitable facilities to meet the needs of patients' families. During our last inspection we found patient bedrooms in both Cornwallis and Mountbatten ward had carpets. This had now been replaced with suitable flooring throughout.

Staff carried out daily safety checks of specialist equipment. We saw equipment was tested, maintained and validated to national standards. We looked at 10 pieces of medical equipment on both Cornwallis ward and in theatres and we saw portable appliance testing stickers on all the electrical equipment, which showed electrical equipment, had been tested and was safe to use. This meant the hospital had assurance that all pieces of medical equipment were tested for electrical safety.

Resuscitation trolleys were easily accessible and available on the inpatient wards and in theatre. They were sealed with security tags to ensure people could not tamper with the products within them without staff knowing. Records showed the trolleys were checked daily as well as once weekly for equipment. All drawers had the correct consumables and medicines in accordance with the checklist. We saw consumables were in date and the trolleys were clean and dust free. The automatic defibrillator worked and suction equipment was in order.

Good

Surgery

Staff told us they had enough equipment to provide safe and effective care and treatment to patients. We checked a sample of consumable items for expiry dates and all were in-date. Store rooms were tidy, well organised and items stored correctly according to policies and procedures. This meant staff could easily locate consumable items.

The hospital did not operate on patients who had a body mass index of 40, therefore the hospital did not have specific bariatric equipment. However, for patients over 100 kilograms the ward would request a hover mattress and informed theatres. Hover mattresses assist with the repositioning patients and lateral transfers.

Waste was separated into colour coded bags to identify the different categories of waste.

The hospital completed regular maintenance, servicing and testing of water systems to minimise the risk of Legionella bacteria.

Staff followed the policy for Legionella and pseudomonas and a site water risk assessment was completed and regularly reviewed. This was in line with requirement of *Health and Safety Executive L8 and Health Technical memorandum 04-01 A and B: guidance on the control of Legionella.*

Assessing and responding to patient risk

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

The hospital had an admissions criteria. Patients with complex co-morbidity and bariatric patients were not accepted as the service did not have the facilities for complex care. The hospital did not admit children or young people under the age of 18 years.

Surgery mostly operated on patients pre-assessed as grade one and grade two under The American Society of Anaesthesiologists grading system. The grading system is used to assess and communicate a patient's pre-anaesthesia existing medical condition. Grade one patients were normal healthy patients and grade two patients had mild diseases only.

Grade three patients were patients with a severe systemic disease that was not life-threatening. Some grade three patients were operated on at the hospital but were always reviewed by the anaesthetist first and risk assessed to determine whether their condition was sufficiently stable to receive treatment at the hospital.

Patients undergoing elective surgery had a pre-assessment to ensure they met the hospital inclusion criteria. This assessment was carried out by a registered nurse and provided an opportunity to make sure patients were fully informed about the surgical procedure and the post-operative recovery period.

The pharmacy team met with patients who were currently taking medications for existing medical conditions or patients who would require medications post operatively, such as anticoagulants. Anticoagulants are medicines that help prevent blood clots and are given to patients who are at higher risk of developing blood clots.

Staff completed risk assessments for each patient at pre-admission and arrival to the ward using a recognised tool and reviewed this regularly, including after any incident.

Staff explained that during pre-assessment they checked the patient's understanding of the treatment they were being admitted for, discussed discharge arrangements, and completed a range of risk assessments and carry out clinical assessments, such as, blood samples, MRSA screening and electrocardiogram (ECG). Patients were swabbed to assess for MRSA as per hospital policy. If results were found to be positive the patient was provided with a treatment protocol to use at home, according to the hospital's MRSA policy.

During the pre-admission appointment any special needs were identified and recorded such as dietary or mobility needs.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

Staff told us there was good communication between the ward and staff in pre-assessment clinic and they worked alongside the consultant anaesthetists in gaining advice if any concerns were identified about a patient's condition.

Patients were assessed and monitored on admission to the ward. Staff completed risk assessments using nationally recognised tools, such as the waterlow score to assess patients risk related to pressure ulcers, mobility, moving and handling, venous thromboembolism (VTE) and the national early warning score (NEWS).

The hospital used NEWS and escalation flow charts. NEWS is a simple scoring system to indicate early signs of deterioration in a patient's condition. NEWS scores were documented in the patient's records and included actions to escalate for review. If a patient's score increased, staff were alerted to the fact and a response would be prompted. The response varied from increasing the frequency of the patient's observations, to urgent review by the patient's consultant.

The hospital completed three monthly NEWS audits. We saw NEWS audits from August 2021 to November 2021 which showed the hospital was 97% compliant in monitoring NEWS. We looked at six patient records during our inspection and the information showed us NEWS scores were completed.

Staff knew about and dealt with any specific risk issues. Staff were trained in care and communication of the deteriorating patient (CCDP). This included training on identifying early signs of sepsis which was based on NICE quality standards. Staff followed the Sepsis six pathway tool and was displayed on the ward. Staff we spoke with were aware of the screening tool and pathway and told us they would escalate any patients displaying these symptoms to the RMO and staff felt confident to do this. Sepsis training was part of the competency training for clinical staff.

Theatre staff told us they were confident in managing a deteriorating patient and had received positive feedback from a local NHS trust in the way they had managed and transferred a deteriorating patient to the NHS hospital.

Patients were visited hourly in their rooms on the ward by nursing staff to assess the needs of the patient. We saw three patient observation charts and documentation which showed this was completed.

There was an alarm system in place to alert medical and nursing staff when immediate assistance was required in the case of an emergency. The hospital had a daily resus hub where a lead from each department attended. The resus huddle lead allocated a specific role to the team such as leader, airway management, defibrillation, recorder and floater. This was in line with best practice guidance.

A communication cell meeting was held was held at 9.30am every morning with discussion on patient numbers, staffing safety, housekeeping capacity, confirmation of safety check completion, fire safety, and staff wellbeing. This meeting also

included discussion of agency staff, contractors and building work being carried out. This allowed all departments to know about any unfamiliar staff that are expected to be seen in the hospital today. We observed this meeting on inspection and saw the meeting was carried out efficiently with a supportive culture including each department nominating staff members for recognition of exemplifying the services values.

The hospital had in place a service level agreement with a local NHS trust for emergency patient transfers to an acute hospital. Staff were able to explain the escalation process and told us there had been no delays when transferring a patient via ambulance to the local NHS hospital.

Consultants were required by the practising privileges agreement they worked under, to be contactable at all times when they had inpatients in the hospital. Consultants were contracted to attend the hospital within an agreed timeframe to respond to any urgent concerns. The RMO and nurses told us that consultants were easily contactable out of hours, such as at night or over a weekend should staff be concerned with a patient's condition. Individual consultants remained responsible for the overall care of their admitted patients. Nursing staff told us they could also gain support and advice from the on call RMO, anaesthetist and pharmacy team.

The RMO had contact details for all patient's consultants if required. If a consultant was on leave, they would arrange for another consultant to cover their case load which the RMO would be aware of.

The hospital had an in date major incident policy and a business continuity plan. These included the loss of mains electricity and generator power, fire alarm activation or system failure, and loss of staffing. The hospital carried out scenarios with staff for emergency situations such as fire and cardiac arrest. Staff were provided with feedback and any lessons learnt were shared with the department.

During our inspection today there was an incident where the hospital lost power outage. We saw senior team assess the situation immediately, emergency power came on as planned. However, the decision was made to suspend all surgery due to the risk of any further issues with power. We found the situation to be handled well and quickly.

Nursing staff on the inpatient wards undertook handover between each shift which included an update on all inpatients and highlighted any specific concerns such as infection risks or safeguarding concerns. During our inspection we saw effective communication of key information to keep patients safe between staff of all grades and roles.

We saw theatre staff carried out the World Health Organisation (WHO) 'five steps to safer surgery' checklist for procedures. The WHO checklist is a national core set of safety checks for use in any operating theatre environment. The checklist had five steps to safer surgery. Staff regularly audited the use and completion of the WHO surgical checklist. The observational audit checklist showed staff was 100% compliant.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. Managers ensured the ward and theatres had enough skilled staff to provide appropriate care and treatment on site. The hospital mainly undertook elective surgery, which meant there was a clear guide to the staffing levels required and were able to calculate staff hours safer staffing hours.

Good

Surgery

Staff we spoke with told us they had enough staff on duty at all times to deliver individualised care to all patients. During our inspection, we saw the ward and theatres had the correct number of staff working on that day.

Any staff shortages in the surgery service and across the hospital were discussed at the daily communication meeting, which was attended by a representative from all hospital departments. Plans would be put in place to make sure services were staffed safely, for example approving the need for additional staff.

Staff told us that sickness and annual leave were usually covered by either their own staff or with the hospital bank staff. Managers made sure all bank staff had a full induction and understood the service. Bank staff knew the hospital well and had completed orientation and competencies prior to working.

The senior nursing team were part of an on-call rota for the inpatient ward. This covered out of hours support.

Surgical staffing

The service had enough surgical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. All patients were admitted under the care of a named consultant. At the time of the inspection there were over 220 consultants practising under practising privileges.

All consultants practising within the hospital required practising privileges at the hospital. Practising privileges is a term used when doctors have been granted the right to practise in an independent hospital. Most of the consultants practising in the hospital also worked within the NHS.

The service always had a consultant on call during evenings and weekends. Practising privileges agreement required consultants to be accessible by telephone 24-hours a day to be responsible for the care and treatment of their patients.

Consultants arranged appropriate alternative named cover if they were unavailable at any time when they had inpatients in the hospital. Consultants and their contact details were easily accessible and staff told us they had never had an issue where they were not supported or could not get in touch with a consultant.

The service had a good skill mix of surgical staff on each shift and reviewed this regularly. There were two RMOs who worked on a rotational basis at the hospital, which was 24-hours a day, seven days a week. The RMOs were employed through an agency the company had a formal contract with.

One RMO was provided onsite daily for medical cover and worked two weeks on, two weeks off. The agency provided RMO cover if there were any absences or if the RMO had been called out at night.

The RMO undertook daily ward rounds, lead on resuscitation of a patient and provide medical guidance to the nursing staff.

Staff told us they had a good working relationship with their consultants, they were comfortable contacting them and found them to be helpful.

The breast consultant employed their own specialist breast care nurse. All breast surgery patients were referred to the specialist breast care nurse for pre- and post-operative care.

Good

Surgery

Records

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

All patient care records were paper based and legible. Patient notes were comprehensive and all staff could access them easily.

Patient individual care records were written and managed to ensure that they were accurate, complete, legible, up to date and stored securely from when a patient had been booked for a procedure until follow up care after discharge had finished. The computers were password protected and we observed that these were locked when not in use. This was in line with the Data Protection Act 1998.

We looked at six patient notes which contained information. Information needed to deliver safe care and treatment was available and easily accessible to the relevant staff for example tests results, care and risk assessments, care plans and patient notes.

We saw completed risk assessments for falls, malnutrition, venous thromboembolism and pressure ulcers. All risk assessments were in line with the National Institute for Health and Care Excellence QS3 – statement one.

All patients received appropriate pre-operative assessments prior to admission for surgery. The pre-operative assessment paperwork was fully completed and formed part of the paper record.

In each patient record we saw there was an appropriate care pathway in place dependent upon the procedure they had. There was evidence to show discharges were planned.

Records were multidisciplinary which meant all relevant information was in one place. In addition, they highlighted risks that were relevant to the procedure.

We found documentation was completed by staff. Medication charts were completed and reviewed by a pharmacist. All notes contained a completed WHO five steps to safer surgery checklist.

Medicines

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

Staff followed the hospital's policies and procedures when prescribing, administering, recording and storing medicines. The hospital had its own pharmacy with their staff being responsible for the supply and top-up of medicines used in theatre and inpatient wards and take home medicines for patients.

Staff followed systems and processes to prescribe and administer medicines safely. Medicines were appropriately prescribed, administered and supplied to people in line with the relevant legislation, current national guidance and best practice evidence.

Staff followed the corporate medicines policy which included information relating to roles and responsibilities, storage of medicines in hospital departments, dispensing, controlled drugs and preparation of medicines.

All medicines on the ward and theatre department was stored securely in locked trolleys, cupboards and fridges with stock medicines stored in locked cupboards in the keycode locked clinical room.

Good

Surgery

Medicines were kept in clinical room with keypad access and cupboards in the room were locked. Keys for those cupboards were kept in a coded key safe or were in the possession of a nurse. This was in line with standards for good medicines management and prevented unauthorised access to medicines.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Nursing staff told us pharmacy staff provided a good service and were available and accessible when needed.

The pharmacy team visited the ward daily to review patient's own medicines on admission, inpatient medicines and to facilitate take home medicines for patients who were due to be discharged.

Patients to be discharged were reviewed and a plan of take-home medicines was in place. Patients on high risk medicines, admissions and discharges were raised and a plan of action was put in place. This meant the pharmacy team could prioritise patients based on risk and reduce the risk of medicine errors and delayed discharges.

Unit and departmental leads completed two monthly medicines management audits. Audits were based on clinical observations and evaluation of medicine charts and treatment rooms. These included the quarterly medicines management audit, missed doses audit, quarterly controlled drug (CD) audit, pharmacy intervention audit and audit of time taken to dispense a prescription. We saw recommendations from the audits were monitored and were completed within required timescales.

Results of the medicines audits were discussed within departmental meetings and any escalation was fed into the hospital clinical governance committee. If there was a particular or common concern raised within audits, then information was also fed through to the corporate clinical governance committee.

We saw medicine audits completed between November 2021 and January 2022 for inpatient wards and theatres were 100% compliant.

Staff learnt from safety alerts and incidents to improve practice. The surgery service had one medicines incident between March 2021 and February 2022.

Medicine fridges were monitored daily and we could see all checks were completed and any temperature anomalies were recorded and followed up with senior staff.

The service was registered with the Home Office and held a CD license as required and in line with the Misuse of Drug Act 1971. We looked at the CD register and a sample of CDs which showed all were stored securely and any CD administered had two signatures recorded as required. Stock matched the register.

Staff carried out twice daily checks of their CD stock and records were clearly maintained. Staff were clear and knowledgeable about the management of CDs. Two registered nurses checked CDs daily.

We did not observe the administration of medicines during the inspection but did review six medicine charts. Patient data such as weight and height were recorded and allergies identified. This meant that medicines were prescribed appropriately for individual patients.

The resuscitation trolleys contained emergency medicines including those for the treatment of anaphylactic shock. Anaphylaxis is an adverse allergic reaction which can be life threatening and requires immediate treatment.

Good

Surgery

Incidents

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

Staff reported serious incidents clearly and in line with corporate policy. The policy included definitions of incidents and their level of harm and how incidents should be reported, investigated and actions taken.

Staff knew what incidents to report and how to report them. Incidents were reported using an electronic system. All staff could access the incident reporting system and had a good understanding of how to complete information.

Staff raised concerns and reported incidents and near misses in line with corporate policy. The hospital used an electronic system for reporting incidents. All staff could access the incident reporting system. Staff said they were encouraged to report incidents or near misses so that effective measures could be taken to minimise ongoing risk to people or the organisation. There was a no-blame culture and staff said they felt confident in reporting incidents.

The hospital had implemented a new process to respond to patient safety incidents called SWARM. This process was part of the hospitals learning from incidents strategy. SWARM was a form of safety huddle which provided a quick response to patient safety incidents. This allowed more immediate action to be taken. The process of SWARM was to gather all staff involved in an incident together.

The meetings were chaired by the circle operating system and a member of the senior leadership team to chair and guide the conversations. Staff were reported to be positive about the SWARM process. Staff described it as being a good experience, everyone was involved in the process and there was positive engagement.

The lessons learnt from incidents were communicated through team meetings and on staff notice boards.

The hospital had not declared any 'never events' between February 2021 and January 2022. 'Never events' are serious largely preventable patient safety incidents that should not occur if a unit has implemented preventable measures. The occurrence of a 'never event' could indicate unsafe practices.

Between February 2021 and January 2022, the hospital reported no serious incidents. However, there had been incidents reported by the surgery team. During the same reporting period there were 106 incidents reported for theatres and 86 for inpatient wards. Examples of incidents were cancelled surgery due to lack on equipment, staff sharps injury and medicines management.

All incidents were discussed at the medical advisory committee, clinical governance committee and senior leadership team meetings.

Staff told us they received feedback on incidents through the SWARM process and through learning. We saw the process of incident reporting and there were recommendations and action plans in place.

There was a duty of candour corporate policy and staff could explain duty of candour and understood their responsibility to be open and honest with patients and their relatives when something had gone wrong. Where a duty of candour

incident had been found it would be reviewed in the senior leadership team weekly incident review meeting. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

Are Surgery effective?

Good

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

Evidence-based care and treatment

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

The service had up-to-date policies and procedures to ensure care and treatment was delivered in line with national guidance and best practice.

The National Institute for Health and Care Excellence (NICE) guidelines were reviewed at corporate level. Policies based on best practice and clinical guidelines were developed corporately and cascaded to the hospitals for implementation. These were reviewed by the clinical governance board and recorded on a local register. Staff were required to sign to say they had read the policies.

Policies we looked at referenced national guidance including the National Institute for Health and Care Excellence (NICE), The Royal College of Surgeons' Standards for consultant led surgical care and the recommendations from the Association of Anaesthetists of Great Britain and Ireland (AAGBI).

Staff could access policy documents on the hospital's database. This meant staff working in the service were following up-to-date practices and providing safe care to patients.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The use of the national early warning system (NEWS) was used to assess and respond to any change in a patient's condition. This was in line with NICE guidance CG50.

Patients were assessed using the American Society of Anaesthesiologist (ASA) grading system for pre-operative health of surgical patients. This is a system to record the overall health status of a patient prior to surgery. The system enabled the staff and anaesthetists to plan specific post-operative care for patients as required.

In theatres, staff monitored patients' temperatures in line with NICE Clinical Guideline CG65- Hypothermia: prevention and management in adults having surgery. Keeping patients warm reduced the risk of complications following surgery. Patients temperature was monitored within an hour of going to theatre, in the anaesthetic room and then every 30 minutes if the operation took longer than 30 minutes.

Staff assessed patients pre-operatively with investigations and blood tests based on NICE guidelines to ensure they were fit for surgery.

Good

Surgery

The surgical service completed a range of audits to ensure healthcare was provided in line with their policies, national guidance and standards. These audits included world health organisation (WHO) checklist, infection prevention and control (IPC) patient equipment, IPC catheter bundles for urinary catheter, IPC catheter bundle for peripheral and central lines, blood transfusion, theatre audit, pain management, patient care, resuscitation, venous thromboembolism (VTE), pain management, deteriorating patients (NEWS), escalation of early warning signs (EWs), health documentation, patient care, pre-assessment, medicines management, controlled drugs, missed doses and administration of drugs.

A peripheral line is a short catheter which is placed in the hand or arm and used for fluids and drugs. A central line is a longer catheter which is placed in a larger vein in the neck, chest, groin or arm area to give fluids and bloods.

The surgical service audit checklist showed between August and October 2021, resuscitation, VTE and pain management did not meet the target of 95% completion and there were required actions to be implemented. Action taken by the surgical service was to address the outcomes of audits directly with staff through ward meetings and regular monitoring was done by the senior and ward managers. The information showed that following the actions taken audit compliance within these areas had improved by November 2021.

Staff followed guidance for surgical site infection prevention and treatment in line with NICE guideline NG125 which included antiseptic skin preparations and antibiotics before skin closures.

Between February 2021 and January 2022, there was one acquired surgical site infection. The hospital followed NICE guidance for preventing and treating surgical site infections (SSI) NICE guidelines CG74. Following discharge, the surgery service completed a follow up call to all surgical patients as part of their 30-day Surgical Site Infection (SSI) audit.

The hospital provided data to the National Joint Registry (NJR). The NJR collected information on all hip, knee, ankle, elbow, and shoulder replacement operations to monitor the performance of joint replacement implants.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. The hospital implemented *NICE guideline CG42, Dementia: supporting people with dementia and their carer's in health and social care* through policy. Staff told us how they support patients with dementia and the dementia aids they use.

Nutrition and hydration

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

Patients waiting to have surgery were not left nil by mouth for long periods. The hospital followed the Royal College of Anaesthetists (RCA) pre-operative fasting guidelines for adults. This recommends that food can be eaten up to six hours and clear fluids can be consumed up to two hours before surgery.

Staff told us they prompted patients to drink clear fluids freely up to two hours prior to surgery as they recognised the recovery benefits of patients who were not suffering the effects of dehydration. Dehydrated patients following surgery were at a higher risk of developing hypoglycaemia, dehydration and distress.

The surgery service provided information on nil by mouth guidance within the pre-assessment letter. It was also advised during the telephone conversation prior to admission.

Good

Surgery

The service offered patients staggered admissions to ensure they did not fast for longer periods than necessary.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Staff completed the malnutrition universal screening tool to assess patient's nutritional status and their needs when they were first admitted and updated this as required. Nutrition and hydration were reviewed during hourly observations post theatre by clinical staff.

Staff did not fully and accurately complete all patients' fluid and nutrition charts where needed. Intravenous fluids were prescribed as appropriate and recorded according to hospital policy. Fluid balance charts were used to monitor patients' fluid intake. We saw three patient records and saw that two of these were completed accurately and fully. One fluid balance chart did not have the totals completed.

The hospitals "post-operative nausea and vomiting care plan" contained clear escalation guidelines for symptom management for patients following surgery. Staff told us the guideline was easy to follow and use.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients had access to a variety of pain relief appropriate for their surgery. We saw completed pain management care plans in patient records. Staff completed regular assessments to make sure that patients' pain was controlled and administered pain control as prescribed.

Patients received pain relief soon after requesting it. Staff assessed patient's pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Staff prescribed, administered and recorded pain relief accurately. We were told the hospital had developed a pain team with the pharmacist and anaesthetist. However, this had only been in place for a short time before the pharmacist left on a temporary secondment. Senior staff told us that for the short time it was in place it had worked well and the service was hoping to start this again once the pharmacy manager returns from secondment.

Patients were given pain information leaflets at pre assessment and on discharge to take home which provided information on how to manage pain following discharge from hospital.

Patient outcomes

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

The service participated in relevant national clinical audits. The hospital had systems and processes in place to monitor, audit and benchmark the quality of services, and the outcomes for patients receiving care and treatment. Managers and staff used results to identify areas for improvement.

Outcomes for patients were mostly positive, consistent and met expectations, such as national standards.

Good

Surgery

The hospital participated in national audit programmes such as the National Joint Registry (NRJ), Patient Reported Outcome Measures (PROMs) and Patient Led Assessment of the Care Environment (PLACE). Data from these audits provided an indication of the outcome or quality of care delivered to patients by the service.

The NJR collects data about joint replacement surgery in order to provide an early warning of issues relating to patient safety. The benchmark for eligible information to be submitted with eligible patient consent was 95%. The service achieved 98.34%, which was higher than the national average of 94.33%.

The benchmark for eligible information to be submitted with the patient NHS number or other identifiable through other supplied data was 95%. The service achieved 99.17%, which was higher than the national figure of 97.07%

The hospitals performance for the NJR was within the expected range or better for all key indicators of data quality other than the individual surgeon revision rates for Hip surgery which was worse than expected.

The hospital collected PROMS data for hips and knee outcomes and this was reported on a national data programme. PROMs data assessed the quality of care delivered to patients from the patient perspective through pre- and post-operative surveys.

Data submitted to PROMs showed, 93.64% of patients reported a positive improvement after their knee surgery and 98.51% of patients reported a positive improvement after their hip surgery.

The PLACE audit is a national system for assessing the quality of the hospital environment and focuses entirely on the care environment and not clinical care provision or staff behaviours.

PLACE data showed the surgery service was above the national average score in cleanliness, food, privacy, condition, appearance and maintenance, dementia and disability. The information showed patients were confident in their care and surgical service.

Managers and staff used the results to improve patients' outcomes. There was a regular audit of the National Safety Standards for Invasive Procedures (NatSSIPs). This is a national safety standard aiming to reduce the number of safety incidents for invasive procedures in which surgical Never Events could occur.

NatSSIPs audit undertaken in April 2021 which showed surgery was 100% compliant. The results of the audit were discussed in the surgery service meetings and information was fed through to the hospitals clinical governance committee.

From February 2021 to January 2022 the hospital reported two unplanned in-patient transfers to the local NHS trust.

From July 2021 to January 2022 there were no cases of unplanned readmissions within 28 days of discharge or unplanned returns to the operating theatre. The senior leadership reported that there was no formal process for the local NHS trust to inform the hospital if a patient presented to them and was readmitted or returned to theatre. However, the service followed up all patients care within 30 days of surgery.

Competent staff

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

Good

Surgery

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All staff with a professional qualification were subject to pre-employment checks to make sure their professional qualification was active and with no restrictions in place.

Managers gave all new staff a full induction tailored to their role before they started work. There was a corporate induction programme for new staff and local induction processes dependent on the hospital department. Staff we spoke with confirmed that induction was relevant, useful and met their needs in the new workplace.

Staff received the appropriate training to meet their learning needs to cover the scope of their work and were given protected time for training. The inpatient wards had one morning per month used for training and the theatre department had one day per month when there were no surgical procedures performed which staff used for training.

All nurses and operating department practitioners (ODP's), who worked within surgical services had recorded validation of professional registration. This meant the hospital conducted annual checks to make sure all the nurses were registered with the Nursing and Midwifery Council (NMC) and ODP's were registered with Health and Care Professionals Council (HCPC).

Managers supported staff to progress through regular development meetings and yearly appraisals of their work. Staff had the opportunity to discuss training needs and were supported to develop their skills and knowledge.

Staff told us they found the appraisal process useful and were encouraged to identify any learning needs. Staff were given the opportunity to work in other areas of the hospital or to complete training to support development.

There were a high number of nursing staff who had been given the opportunity to complete advanced life support training or they were due to start the training. We spoke with a nursing associate who was working within the inpatient ward as a healthcare assistant and was supported to apply for funding to complete nurse training.

Resident medical officers were trained in advanced life support and would lead the response team in the event of any unexpected patient risks or emergencies until a consultant and ambulance arrived.

Most consultants held NHS contracts and they maintained their skills by working in the trust and had their appraisals completed by a nominated deputy medical director. The hospital required evidence of appraisals including a personal development plan and all consultants completed an application form for granting practising privileges. Practising privileges were reviewed every two years unless there were concerns about a practitioner's performance.

There was a corporate process for the granting of practising privileges and the management of checks to ensure General Medical Council (GMC) registration, indemnity cover renewal and mandatory training and appraisals were undertaken.

The service supported staff to undertake training in order to maintain their professional registration and revalidation. Revalidation is a process to ensure staff had undertaken training and development to maintain their skills to remain on the professional registers.

Multidisciplinary working

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

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

Good

Surgery

The hospital had a daily communications meeting, which took place every morning and was attended by the senior leadership team and a representative from each department in the hospital. The meeting was held at 9.30am every morning with discussion on; patient numbers, staffing safety, housekeeping capacity, confirmation of safety check completion, fire safety, and staff wellbeing. This meeting also included discussion of agency staff, contractors and building work being carried out. This allowed all departments to know about any unfamiliar staff that are expected to be seen in the hospital today.

We observed this meeting on inspection and saw the meeting was carried out efficiently with a supportive culture including each department nominating staff members for recognition of exemplifying the services values.

There was a strong multidisciplinary team approach across all areas we visited. Staff of all disciplines and grades, worked together throughout the hospital. Staff reported that they worked well as a team and all team members were aware of who had overall responsibility for each individual's care.

We saw clear communication between staff and observed safe and effective handovers of care, between the ward, theatre and recovery staff. Medical, nursing and theatre staff reported good working relationships with the local NHS acute trust.

The resident medical officer attended the twice daily ward handovers, this meant they were informed of patients being admitted and who was scheduled for theatre.

Staff discussed discharge planning with patients at the pre-assessment appointment so that effective plans were in place to meet patient need when discharged. We saw effective discharge plans in patients' notes. Discharge letters were sent electronically to patients' GP's on the day of discharge, with details of the treatment provided, follow up arrangements and medicines provided.

Seven-day services

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

The hospital did not provide emergency care. All surgical patients followed the elective pathway and admissions were booked in advance.

Theatre lists were undertaken Monday to Friday from 8.30am to 8pm and Saturday from 8.30am to 4pm.

The theatre manager and director of clinical services managed the theatre schedule.

There was a service level agreement in place with the local NHS trust, to be able to transfer patient who require intensive care support.

The hospital was open seven days a week 24-hours a day to care for patients after surgery that needed to stay in hospital overnight and the weekend.

Theatre staff were on-call should there be any unplanned returns to theatre. For this, they provided an emergency service 24-hours a day and seven days a week and had an established on-call rota.

Consultants reviewed patients daily and either visited or telephoned the service for an update at weekends. Consultants were available out of hours, during weekends and on call 24-hours a day for patients in their care.

Good

Surgery

The resident medical officer (RMO) was based on-site at the hospital and provided a 24-hours a day, seven days a week service. The RMO provided clinical support to consultants, staff and patients.

Allied health professionals including physiotherapy and radiology staff provided care and support out-of-hours.

The hospital had a pharmacy which provided both inpatient and outpatients services. The pharmacy was open from 9.00am to 5.00pm Monday to Friday. Outside of these hours the RMO and nursing staff dispensed medications which had already been prescribed, with access to an on-call pharmacist evenings and weekends to address any pharmacy related queries.

The pharmacist provided an on-call service 24-hours a day seven days a week. There were appropriate processes in place for staff to obtain medication from the pharmacy department out of hours.

Health promotion

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

Patients attended pre-operative assessment appointments where their suitability for surgery was checked. This included the completion of a health questionnaire, and an opportunity for the nurse to provide advice or refer patients on to other appropriate services if they required these services.

Patients having joint surgery, would see a physiotherapist on a one to one basis with tailored information specific for the patient. Patients were given pre-operative and post-operative exercises and assessed for need of occupational therapy or support from social services.

The service limited the number of patient information leaflets due to the continued risk of COVID-19. However, leaflets were available via the clinical staff, consultants and allied health professionals.

The hospital used laminated health promoting posters relating to COVID-19 in public areas. These reminded patients of the importance of physical distancing and washing hands to reduce the risk of transmission of the virus.

Staff on the ward encouraged patients to mobilise early post-surgery to help prevent post-surgical complications and encourage independence.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. The hospital had a Mental Capacity, Deprivation of Liberty Safeguards and Restrictive Practice policy. The policy set out whose responsibility it was to obtain consent and when to use implied, verbal and written consent and for staff to understand and effectively implement the statutory requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2007. Staff told us they supported patients to make their own decisions wherever possible.

All staff including bank and agency working within the hospital had completed relevant training and knew how to support vulnerable patients.

Good

Surgery

Patients said doctors fully explained their treatment and additional information could be provided if required. Consent forms we saw in patients' records were fully completed and detailed the procedure planned and the risks and benefits of the procedure. The hospital consent forms complied with Department of Health guidance. The service had a two-stage consent process. Patients' records showed consent was reviewed on the day of their surgery as part of their pre-operative checklist.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Patients were risk assessed on an individual basis and adjustments put in place to deliver safe care to the patient if needed.

Staff knew the guidance to follow to ensure decisions were made in patients' best interest and took into consideration patients' wishes. Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS). Staff could describe and knew how to access policies and get accurate advice on the Mental Capacity Act and DOLS.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Training on mental capacity and DOLS was included in the mandatory safeguarding adults training.

Are Surgery caring?

Good

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

Compassionate care

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

Staff throughout the surgery service put patients at the centre of what they did. During our inspection, we saw positive interactions between staff and patients. We saw staff treat patients with warmth and care, they were courteous, professional and demonstrated compassion to all patients. Patients were kept well informed about their care and were involved in making decisions about their treatment.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients. Peoples' privacy and dignity was always considered. Staff always knocked before entering a room.

The Patient Led Assessment of the Clinical Environment (PLACE) took place in 2019. PLACE was unable to be assessed in 2020/2021 due to COVID-19. The privacy and dignity score was 100% which was higher than the national average of 84.9%. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients. Staff knocked on the patient's door before entering their room and the door and curtains closed when requested.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients in a respectful and considerate way. Patients we spoke with during our inspection commented positively about the care and treatment they had received.

Good

Surgery

The hospital monitored patient feedback from their Patient Satisfaction Survey and the NHS Friends and Family Test (FFT). The FFT is a survey measuring patient's satisfaction with the care they have received and asks if they would recommend the service to their friends and family. The scores related only to those patients seen and treated on behalf of the NHS.

Between January 2021 to December 2021the FFT inpatient scores were mostly above the England average of 96%. However, in April, May and June 2021 the scores were slightly below the England average at 95.6%, 92.9% and 94.2% respectively.

Staff at the hospital encouraged patients to complete patient satisfaction questionnaires to review and improve patient experience. The patient satisfaction survey report showed the service scored 98% for "Overall experience of service" and 98% for "Overall impression of Theatre staff".

The service scored highly in their friends and family test survey. Patients consistently reported their experience of the service as very good or good. The lowest rate in the last 12 months was 92.3% in May 2021.

Patients felt confident in the quality of care provided by consultants and nursing staff.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff working in the surgery service showed sensitivity and support to patients and those close to them. Staff understood the emotional impact of having surgery has on patients and their families.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff told us they sometimes saw patients who appeared anxious due to the nature of their surgery. They understood the need to give patients appropriate and timely support and information to cope emotionally with their care, treatment or condition. Theatre staff told us if needed they would give additional reassurance to a patient if they were anxious about their surgery.

We were given an example of nursing staff who had supported a distressed patient following their surgery and return to ward. The nursing staff had stayed over their shift to ensure the patient had one to one support and arranged for the patient to be able to see a family member for reassurance.

Stop the line was a process where all staff stopped what they were doing to assess an incident or situation. Staff told us of an incident where a patient became extremely distressed going into theatre. Staff stopped the line, assessed the situation and determined that the best outcome for the patient was to have their family with them and for the surgery not to take place at that time.

The theatre team received feedback from the family in the way in which they care for and supported the patient.

Staff told us the care and support they gave to patients had increased as the hospital continued to not allow visitors or relatives into the hospital due to the COVID-19 pandemic. Staff were aware this could lead to patients feeling isolated and vulnerable.

Good

Surgery

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Patients told us they felt involved in the planning of their care. They told us they had received full information about their diagnosis and treatment and the care and support which would be offered following the procedure. Information shown on the patient satisfaction survey showed the surgery service scored 100% overall in patients feeling involved in their care and treatment and scored highly with patients feeling they were able to talk to someone about their worries.

We saw staff introduce themselves to patients, explain their role and the examination that was about to be performed.

Are Surgery responsive?

Good

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

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the needs of those who chose to use the service. Admissions to the surgical ward were all elective and planned in advance.

The hospital worked with the local Clinical Commissioning Group (CCG) in planning services for NHS patients. The service mostly saw private patients. However, since the COVID-19 pandemic there was an increase in NHS patients attending the hospital for surgery and treatment. The hospital supported the need of the local community during the COVID-19 pandemic. It had worked closely with the local CCG and NHS trust to provide a range of services and specialities. This included identifying how the hospital could provide COVID-19 safe environments and services that were not being delivered by the local NHS trust due to the pandemic.

Facilities and premises were appropriate for the services being delivered. The hospital had an admission criteria which meant the hospital only admitted patients whom the hospital had facilities to care for.

The hospital was a designated enhanced recovery site for elective surgical patients, who required non-invasive monitoring such as blood pressure monitoring, pulse oximetry and electrocardiogram (ECG). There were no facilities for emergency admissions. However, the hospital had a standard operating procedure (SOP) for care of the deteriorating patient.

Patients who became unwell and deteriorated to a level which could not be treated at the hospital due to requiring high dependency care (HDU) or intensive care (ITU) facilities. These patients were emergency transferred to the local acute NHS hospital as part of the SOP where they were able to receive ITU or HDU care.

A consultant anaesthetist escorted all high-risk patients to the acute hospital and would give a handover of the patient to the receiving doctor and nurse responsible for the takeover of the patients care.

Good

Surgery

The service had systems to help care for patients in need of additional support or specialist intervention. Patients completed a pre-admission medical questionnaire to identify patients with certain medical conditions, patients who may need further assessment or patients requiring further specialist support. Patients arrived at different times to enable staff to manage admissions and to reduce the patients waiting times for patients.

Managers ensured that patients who did not attend appointments were contacted. Between February 2021 and January 2022, there was 25 patients who did not attend the hospital for their surgery. Senior staff told us that all patients were called the day before their admission to the hospital. This was to confirm patient attendance and to go through what the patient was required to bring into hospital. Staff ensured patients who did not attend appointments were contacted to check on their welfare and to find out why they did not attend

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. All surgical patients attended a pre assessment appointment so staff could assess patient needs prior to admission. Staff used this information to provide safe care and treatment and mitigate any possible risk to the patient. The hospital did not have the facilities to support the care of patients with high complex needs. Therefore, this patient group was not admitted to the hospital. However, patients who had a learning disability or dementia could be admitted following the appropriate risk assessments had been carried out.

The hospital had links with dementia friendly communities to support patients and relatives coming into the hospital with a diagnosis of dementia. Staff we spoke with told us they had completed dementia awareness training but rarely treated patients living with dementia. Staff were 100% compliant in completing their mandatory training in dementia.

The hospital was accessible to patients with a physical disability, as it was all on one floor. The inpatient ward had a larger room available for wheelchair users. We saw wheelchair accessible toilets. Each patient room had easy access showers with no steps, there were handrails in place and stools in the showers to provide extra support when showering.

Staff completed equality and diversity training annually as part of their mandatory training. At the time of our inspection, training compliance across staff working in the surgery service was 99.4%.

The service had information leaflets available in languages spoken by the patients and local community. The service had access to an interpreting service for patients whose first language was not English and signers if needed. We saw leaflets in different languages which explained what to expect when having a general anaesthetic.

Access and flow

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

The hospital followed corporate and local policies and procedures for the management of the patient's journey, from the time of booking the appointment until discharge and after care.

Good

Surgery

All patients having a general anaesthetic were assessed in a pre-assessment clinic prior to their surgery. Patients' discharge planning began at the pre-admission assessment stage with involvement of pharmacy and physiotherapy.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

Since the pandemic, the hospital worked with the local NHS trust to alleviate the current pressures within the NHS and reduce patient waiting times for surgery. This had led for the hospital to review their current processes to manage waiting lists for both private and NHS patients.

Patient waiting times were monitored during a weekly activity utilisation meeting to identify capacity and demand. The meeting was attended by the operations manager and local NHS trust. The purpose of the meeting was to discuss The Chaucer Hospital supporting the NHS with long waiting lists.

We saw factors affecting service delivery was discussed at the daily communication cell meeting and in the minutes of monthly meetings with the hospital, NHS trusts and local clinical commissioning groups (CCG).

The hospital offered either day-case or inpatient surgical procedures. Day-case surgery did not require an overnight hospital stay. However, day-case patients were told to bring an overnight bag with them, in case they were required to stay overnight. For example, if the patient became unwell following the procedure.

Inpatient surgery required the patient to remain overnight or longer after the surgery was completed, for care or observation.

Private healthcare network data (PHIN) showed between July 2020 to June 2021 there was a total of 6,125 total procedures carried out at the hospital, 3,470 of those procedures were private patients and 2,870 were NHS patients. Theatre bookings and capacity were reviewed weekly.

Theatre staff, consultants, and anaesthetists had an on-call rota arrangement to manage any unexpected returns to theatre including weekends and overnight. This meant staff were available to ensure patients had timely access to services.

Managers worked to keep the number of cancelled operations to a minimum. There were 1025 cancelled patient surgeries between February 2021 and January 2022. Of those, 601 operations were cancelled at the request of the patient or due to the patient failing to attend and 139 operations were cancelled due to the patient being unfit for surgery. The remaining 285 cancellations were for non-clinical reasons such as, consultant availability, booking made in error, equipment availability, hospital overbooked and unfit for surgery. All patients were routinely offered a new date within 28 days of a cancelled procedure.

Referral to treatment (RTT), under the NHS Constitution, patients in England says patients 'have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible'. The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment

RTT waiting times and capacity bottlenecks identified, were discussed and actioned in the weekly activity utilisation meeting. The hospital had weekly meetings with the local NHS Trust to discuss what support the hospital could offer to help with the NHS trust 18-week waiting time backlog.

RTT's were reviewed weekly with the patient administration manager and operations manager to understand any capacity issues.

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Information received from the hospital showed the majority of procedures RTT were scheduled before 18 weeks which met the NHS Constitution target. With 239 procedures scheduled between zero to four weeks, 243 procedures scheduled between five to nine weeks, 236 procedures between 10 to 14 weeks and 170 procedures between 15 to 19 weeks. However, there were 179 procedures which fell between 20 to 59 weeks which did not. Some of the reasons given for not meeting the target was procedure cancelled due to COVID-19, patient cancellation and general surgery demand.

To support the demand for NHS patients requiring surgery and to improve patient waiting times for treatment the hospital had recently employed a new orthopaedic hand and wrist surgeon, an upper gastrointestinal surgeon and gynaecology. The hospital told us there had been delays in consultants starting due to the COVID-19 pandemic. To mitigate and prioritise procedure waits all referrals were currently triaged by the clinical chair.

Staff confirmed patients who were identified as high risk, such as diabetic patients, were usually scheduled for surgery at the beginning of the theatre list. This was in case high risk patients developed complications during their procedure. High risk patients such as diabetic were identified during pre-assessment and this was communicated to the inpatient staff and theatres.

Managers and staff worked to make sure that they started discharge planning as early as possible. Discharge began at pre-assessment and was continued to be monitored on admission, in regard to medication and support. Patients were discussed during the daily huddle and the pharmacist arrange take home medication. At discharge, all patients were given an aftercare booklet which included a direct telephone number to the ward. Patients could call this number and speak to a nurse if they had any concerns. The information included a discharge letter for the patients GP as well as aftercare and advice leaflets on pain and deep vein thrombosis.

Learning from complaints and concerns

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

The hospital followed the corporate complaints policy which gave clear processes and timeframes for dealing with complaints.

Staff understood the policy on complaints and knew how to handle them. Staff told us they felt confident in handling patient's complaints and the reporting process.

From February 2021 to January 2022 there were 10 complaints raised within the surgery service, with two complaints raised for theatres and eight for the inpatient ward. Most complaints were from patients who felt that had long waits on the ward for surgery.

The service clearly displayed information about how to raise a concern in patient areas. We saw information on how to raise a complaint around the hospital and ward area.

Good

Surgery

Patients, relatives and carers knew how to complain or raise concerns. Patients could make complaints in various ways, verbally, by telephone and in writing by letter or email. There was a hospital leaflet explaining the complaint procedure and the corporate website had a detailed page explaining the complaint procedure and how to make a complaint.

Managers investigated complaints and identified themes. The senior leads within the surgery service would lead on any complaint and would offer the complainant an opportunity to meet with them to discuss the concerns raised. We saw evidence that hospital complaints were discussed and addressed at the clinical governance meetings and departmental meetings. Any complaint themes or trends were analysed and actions put in place to stop them occurring again.

Staff said learning from complaints and concerns would be communicated to them mainly at handovers, team meetings, emails and notice boards. Complaints were also discussed at the daily communication meeting meaning heads of departments heard about complaints from elsewhere in the hospital. This promoted shared learning from incidents throughout the hospital.

Are Surgery well-led?

Good

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

Leadership

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

The hospital had a clear management structure in place with defined lines of responsibility and accountability.

The hospital was led by an executive director who had overall responsibility for the hospital. They were supported clinically by the director of clinical services, director of operations, clinical chair and quality and risk manager.

Since our last inspection, a clinical chair was appointed to the hospital. The role of the clinical chair was to provide clinical leadership, developing a culture of safety, quality and continuous improvement. The clinical chair was responsible for medical performance and clinical governance.

Under the director of clinical services were the heads of department and for surgery was the inpatient wards and theatre managers. Working closely alongside them was the pharmacy manager, infection prevention and control lead and imagery and physiotherapy manager.

The non-clinical service leads, such as engineering and the patient administration manager, were managed by the director of operations. The service had leaders who had the skills, knowledge, experience and integrity to run the service.

We were told the executive director was visible and would visit the areas daily. All staff knew who the executive director was and felt confident to approach them.

Good

Surgery

The surgery service had strong, effective leadership. The clinical service managers were well supported by senior nurses. Staff knew the service well, were organised and had a good understanding of the challenges and priorities within the service. For example, there had been a change in demand on the surgery service over the COVID-19 period and staff were redeployed to other areas in the hospital which were treating a larger number of NHS patients. The ability to upskill staff to enable rotation was a continued priority for the service.

The clinical services manager for the inpatient wards had worked for the service for a number of years. They were not working during our inspection. The clinical service manager within theatres was new in post but found to be experienced in her role and keen to promote learning and staff development within the service.

Staff spoke highly of both clinical service manager and senior nursing staff and we got the impression they were well respected within their team.

We found the senior leadership team supported staff to develop their skills. Staff had been provided with development opportunities to grow their leadership and communication skills. Staff were given the opportunity to work in other areas of the hospital for development and a number of staff had applied or completed the advance life support training.

Vision and Strategy

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

The Chaucer Hospital had their own vision and strategy that was aligned to the corporate vision and strategy.

The hospital vision and strategy was devised by staff, with the executive team learning from the staff survey to shape the vision for the hospital and there was a clear focus on patient outcomes, patient experience, staff experience and optimum value.

There was a clear hospital statement which was, “To provide the high quality, safe and compassionate care that patients need and expect.”

The service had a vision for what they wanted to achieve. The hospitals vision was “To be recognised as outstanding by patients, staff and regulator.”

The service had a set of values and beliefs to help them achieve their vision and purpose. Their values were;

- To value people who are selfless and compassionate.
- To value people who are collaborative and committed.
- To value people who are agile and brave.
- To value people who are tenacious and creative.

Their beliefs were;

- Patients come first.
- To believe in their people.
- ‘Good’ is never enough
- To be openminded and innovative.

Good

Surgery

Leaders monitored their progress against their strategy and managers met to review progress against their strategy monthly.

Staff understood the vision, values and strategy and what their role was in achieving them. Staff were involved in discussions to shape the vision and strategy for the hospital.

The heads of departments attended quarterly strategy days to engage in the hospital strategy and operational running of the hospital.

Culture

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

Staff were welcoming, helpful and professional in their communication with each other, patients and visitors. Staff described good teamwork and respect amongst their colleagues, and we could see this in practice when we inspected the theatre and ward areas.

Staff we spoke with felt supported, respected and valued in their working environments. Staff told us they felt supported as individuals in their roles but also as part of the wider hospital too. Staff spoke positively and passionately about the care and the service they provided. Quality and patient experience were seen as a priority and responsibility for everyone.

Senior leaders celebrated success with the wider team and we were told examples of this during our inspection. The hospital offered monthly awards for staff who went 'Above & Beyond'. This was to recognise staff contributions during their work. Staff were encouraged to nominate a colleague who they felt had gone above and beyond in the course of their daily work.

The 2021 hospital staff survey showed that most staff felt valued, they were proud to work for the organisation, they felt well supported by their managers and they strongly felt a strong sense of family within their team.

The service had an open culture where patients, their families and staff could raise concerns without fear. Staff said they raised concerns and these were viewed as opportunities to improve the service. We saw reminders from senior leaders to report incidents and raise concerns with the aim of improving the service and maintaining patient safety.

The hospital promoted equality and diversity within the service. The hospital reported on workforce race equality standards (WRES) focusing on ethnic minority staff proportions in the hospital and access to development opportunities. The WRES report data from the last year did not indicate any concerns in equality and diversity for ethnic minority staff.

The hospital had recently been accredited with the workplace well-being charter. The accreditation was for organisations who were committed to improving the health and well-being of their workforce. The hospital had a notice board for wellbeing at the front of the hospital which showed what the hospital was doing to promote wellbeing and how they support staff.

Staff recognised patients, relatives of patients and staff could be carers. The hospital had linked together with a local carers support charity and had become a carer friendly hospital. The charity completed carers assessments and signposted people referred for additional support and respite. The hospital had referred patients' relatives for additional support to the charity for respite and installation of equipment.

Good

Surgery

Governance

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

The hospital had a governance framework through which the hospital was accountable for continuously improving their clinical, corporate, staff and financial performance.

The hospital followed the Circle Health Group corporate governance assurance framework which sets out how the hospital organises their governance arrangements from the department in the hospital to board at Circle Health Group. Staff at all levels were clear about their roles and understood what they were accountable for, and to whom.

The service held meetings to discuss and learn from the performance of the service. Clinical heads of departments had a monthly clinical governance committee which included discussion of learning from incidents, safety alerts, patient feedback and audits. Information for escalation from the clinical governance committee fed into the hospital's managers then up to the Circle Health Group regional team.

Department managers attended the hospital's clinical governance meetings and discussed how their departments were performing within the Medical Advisory Committee (MAC), Senior Management Team (SMT), health and safety, medicines management, infection prevention and control meetings. They could see the key quality issues of safety, risk, clinical effectiveness and patient experience for their departments. It was up to the department managers to disseminate this information to their teams and to act on any issues arising.

Patients booked into the hospital for cancer operations were discussed weekly at the Activity Utilisation Meeting. The meeting was to ensure all cancer patients current treatments had been reviewed within a multidisciplinary meeting prior to attending the hospital for surgery.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The roles and responsibilities expected of consultants under practising privileges was detailed in the corporate 'Practising Privileges policy'.

The hospital had a medical advisory committee to ensure doctors working in the service continued to meet the required standards to practice at the hospital. The MAC made sure any new consultant was only granted practising privileges if deemed competent and safe to practice. We saw MAC minutes which practising privileges was always a standard agenda item.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

There were clear and effective processes for identifying, recording, managing and mitigating risks. The hospital followed the circle corporate risk policy. This policy detailed the aim of risk management, explained what risks were and how to identify, record, review and mitigate risk.

Good

Surgery

The hospital held regular clinical governance committee meetings where discussion of the hospital's top five risks was a standard agenda item.

Each department had their own risk register, which was managed by the clinical service managers and this fed into the hospital risk register. We looked at the risk register for theatre and inpatient wards. The top risks on the surgery service risk register was staffing levels, falls and the impact of COVID-19.

The service had plans to cope with unexpected events. We saw staff efficiently and safely managing an electrical power failure during our inspection.

From talking to staff and reviewing documentation we saw the surgery service and senior hospital managers were able to recognise, rate and monitor risk. This meant the hospital and surgery service could identify issues that could cause harm to patients and staff and threaten the achievement of their services.

Information Management

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

The service collected reliable data and analysed it. Staff and leaders collected and analysed data on staffing, quality and safety. This included monitoring of compliance with; surgical safety checklist, hand hygiene, use of personal protective equipment and medicines management.

Managers had a good understanding of performance monitoring, with information on quality, operations and finances used to measure improvement, not just assurance.

The information systems were integrated and secure. The service used paper records which were kept in locked clinic rooms or behind the reception desk that was always staffed. Electronic information was kept on computers that were secured with usernames and passwords for each member of staff preventing unauthorised access. Staff logged out of computers when not in use.

The hospital was audited by an external company to monitor compliance with information security management standards. The hospital had an information security officer and a Caldicott officer. A Caldicott officer is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.

There were effective arrangements to make sure data and statutory notifications were submitted to external bodies as required, such as local commissioners and the Care Quality Commission . There was transparency and openness with all stakeholders about performance.

Staff had access to a range of policies, procedures and guidance which was available on the hospital's electronic system. Staff also told us they used IT systems to access the e-learning modules required for mandatory training.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Staff told us information was displayed clearly and was easily accessible including information on paper records.

Good

Surgery

Engagement

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

The hospital and surgery service encouraged patients to give feedback about their experience to help improve services. The hospital did this through patient satisfaction questionnaires, feedback and suggestion cards and to complete reviews on search engine websites.

The hospital reviewed and monitored patient satisfaction through their clinical governance committee and used the information to form improvement and learning.

The hospital engaged with all staff in many ways. For example, a monthly team brief from the executive director and noticeboards in the hospital. Staff we spoke with during our inspection in the surgery service said the senior leaders and executive team engaged well with them and their views were sought.

The hospital also conducted surveys to receive feedback from staff. The latest staff survey showed that staff felt they could make a valuable contribution to the success of the organisation and felt happy with their balance between work and home life.

The service engaged with the public and local organisations. Staff had donated gifts for Christmas and raised awareness for a local charity that helped homeless people. Staff had been working with local charity groups to raise awareness and funds for their work. Staff had held a charity bake off raising money for a local mental health support charity.

Staff from the local commissioning group and NHS acute trust provided positive feedback about The Chaucer Hospital's engagement and responsiveness to the needs of local people.

Learning, continuous improvement and innovation

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

The senior management team organised monthly half day team meetings. This enabled teams to undertake a team meeting, review performance data and patient feedback and arrange any department specific training.

The surgical service obtained accreditation in 2021 with the Association for Perioperative Practice (AfPP). To gain the accreditation an independent audit and peer review showed the surgical service had met the AfPP standards and recommendations for safe perioperative practice.

The service participated in the Circle Health Groups "Patient Hour" initiative which describes time dedicated to exploring patient feedback and experience as a team. This initiative focuses on teams thinking about ways to improve the patient experience of the service. Patient hour gave staff the opportunity to explore patient feedback and experience and the information was shared within team meetings for learning.

The hospital had introduced "The Green Guardians" which are staff who have an additional role to ensure the hospital recycle and collaborate with recycling in the local community. In the first month the hospital recycled 86% of hospitals general waste. We saw clear guidance on segregating recyclable waste and staff following this by putting suitable nonclinical waste in designated recycling bins.

Good

Surgery

The service supported development and improvement opportunities for staff. A day in their shoes offered opportunities to staff to work in other areas of the hospital to gain experience and knowledge.

Staff were proactive with “Stop the Line”. Stop the line gave any member of staff clinical and non-clinical to stop a situation that may cause harm to a patient. The activity taking place at that moment is stopped and staff would review and manage the current concern. Staff told us this worked well and staff felt confident and supported to challenge. Examples of incidences where stop the line was put in place included a patient who became distressed going into theatre and staff challenging the incorrect donning of masks or gloves.

Incidents were reported using the SWARM approach. SWARM was used to identify at the time and place of an issue raised or an circumstance a person was affected by. Relevant people gathered to assess an incident or issue.

Good

Outpatients

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

Are Outpatients safe?

Good

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

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. There were 40 mandatory training modules and compliance to all modules met the provider's target of 90%. The service had an average compliance rate of 99% with the lowest compliance rate in 'adult immediate life support' at 90.2%. Staff told us they had time to complete mandatory training including having one half day a month dedicated to training and team meetings.

The mandatory training was comprehensive and met the needs of patients and staff. Staff said their training was helpful and prepared them for their roles. Staff completed mandatory training on subjects to support them in their roles including; consent, conflict resolution, and life support.

Clinical staff completed training on recognising and responding to patients with dementia. Staff completed training in dementia awareness with a compliance rate of 100%.

Managers monitored mandatory training and alerted staff when they needed to update their training. The service's training system alerted staff when their training was due soon and when they were overdue. Managers reminded staff when they needed to complete their training individually and provided group reminders at the daily site meeting.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Records showed all eligible staff had completed safeguarding vulnerable adults' level 1, 2, 3 and safeguarding children level 1 and level 2. We saw records showing all eligible staff had completed 'prevent' training. Prevent training aims to ensure the safeguarding of children, adults and communities from threats of terrorism. All the modules met the services target of 90%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff had a clear understanding of how to recognise and report abuse. The service had a safeguarding lead to provide advice to staff if they were unsure about any aspect of the safeguarding process. Staff said they were able to approach them for support any time they needed. Staff received training in 'equality and diversity' with a compliance rate of 99%.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had up to date policies for safeguarding children and vulnerable adults. These policies provided support including a flow chart to follow through if staff were unsure what to do next. Staff knew how to report abuse including calling the police if there was an immediate risk of safety to a child.

Staff followed safe procedures for children visiting the service. Staff were able to describe how to identify risks of abuse to children that visited the department. The only children in the department were those attending with an adult as the service did not treat children.

The director of clinical services and the quality and risk manager attended regular regional safeguarding meetings with other Circle Health Group hospitals to discuss safeguarding themes and learning from safeguarding incidents.

Cleanliness, infection control and hygiene

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

Staff received training in infection prevention and control. The service had three mandatory training modules for infection prevention and control; with one for non-clinical staff. All these modules had a compliance rate of 100%.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. All areas in the outpatients department were visibly clean. The waiting areas and clinic rooms had chairs made with a wipeable material to promote effective cleaning. All furnishings throughout the outpatients department were all well-maintained. Well-maintained furnishings make cleaning more effective as dents and rips in furnishings can prevent thorough cleaning.

The service generally performed well for cleanliness. The service participated in a patient-led assessments of the care environment (PLACE). The last audit showed cleanliness was 100% for the outpatients department.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Records showed cleaning was completed everyday apart from days the department was not open.

Staff followed infection control principles including the use of personal protective equipment (PPE). All staff were 'bare below the elbows' and dressed in line with the service's policy. Staff had access to PPE including; aprons, masks and gloves in a variety of sizes. Staff used PPE in line with the service's policy.

All staff cleaned their hands before, during and after patient care in line with the World Health Organisation guidance on the "five moments for hand hygiene". We saw posters reminding staff of these five moments. Reception staff reminded staff, patients and visitors on entering the department to use hand gel and swap their face mask for a clean one issued by the hospital.

Staff completed hand hygiene audits to monitor compliance every other month. Records showed outpatients staff had achieved 100% compliance over the last three audits.

The hospital had taken additional precautions to protect patients and staff from COVID-19. The hospital had two entrances the main entrance to the hospital and the entrance for the outpatients department, both had signs to instruct patients, visitors and staff to use the hand gel and put on a clean mask. Reception staff at both entrances asked all people entering the hospital about symptoms of COVID-19 and contact with anyone with symptoms. Signs reminded people to clean their hands and keep a safe social distance. Within the outpatients department, there were floor signs to remind people to walk on the left side of corridors to improve social distancing while moving around the department.

Staff managed sharp clinical waste in a way that reduced the risk of spreading infections. Sharps bins were assembled correctly, and these were not overfilled. Staff used temporary closure lids to reduce the risk of accidental sharps injuries.

The service monitored their effectiveness at reducing the risk of spreading infections. Staff held an infection prevention and control meeting once every three months which included discussion on training compliance, audit performance, antibiotic stewardship, and updates to infection prevention and control policies.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff cleaned equipment after patient use and used green labels saying 'I am clean' which showed when items was last cleaned.

Environment and equipment

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

The design of the environment followed national guidance. The department had seamless floors with a smooth, slip-resistant and easy to clean finish. This was in line with the Health Building Note (HBN) 00-08 for flooring. Since our last inspection, the carpet in the waiting room was replaced with laminate flooring. There was no carpet in the outpatients department. This was in line with HBN 00-09 for carpets.

Staff carried out daily safety checks of specialist equipment. The emergency resuscitation trolley was stored in the waiting room which was within a short distance to all areas of the outpatients department. Staff carried out daily checks on this equipment and recorded when they replaced items. Records for the last four weeks showed checks were carried out every day the department was open.

The service had suitable facilities to meet the needs of patients. The department had two waiting areas to allow for patients to wait closer to the room used by their consultant. Reception staff also had buzzers to allow patients to wait in their car and be called in when their consultant was ready for them. This allowed patients to limit their exposure to other patients and prevent overcrowding. The department had 10 clinic rooms used by consultants to see patients with one set up for eye assessments. They had a treatment room for wound dressings and nursing interventions. The department had one minor procedure room next to a recovery area with space for two patients.

The service had enough suitable equipment to help them to safely care for patients. Staff told us they always had the equipment they needed including acquiring new equipment for the department. This included buying new equipment to improve services as well as additional items of equipment where multiples provided an improved patient experience. Staff said since the hospital became part of Circle Health Group the investment in equipment had improved greatly. Equipment in the outpatients department was stored in an organised way, was clean, dust-free and had the required up-to-date checks.

Consumables were stored neatly in the storeroom and in treatment areas. We looked at 15 items, all of which were within date, dust free, and sealed.

Patients attending the outpatients department were booked in at the outpatients reception desk which had clear plastic screens to protect patients and staff from the spread COVID-19.

The waiting area was spacious and light, with chairs and wheelchairs available to meet patient's needs. There was a drinking water dispenser with disposable cups and a sign asking people to use the hand gel before using the water dispenser.

Staff disposed of clinical waste safely. Staff correctly sorted waste into clinical and non-clinical waste. The service had clinical waste bins with clear indication about what should be disposed of in them. They had domestic waste bins for non-clinical waste which had signs on to remind people what could and could not be put into these bins. Staff also separated recyclable non-clinical waste to reduce their effect on the environment.

The service had, and maintained, fire safety equipment to ensure it was fit for use in the event of a fire. The service had carried out yearly checks on fire extinguishers and these were secured to the wall where staff could access them quickly.

Assessing and responding to patient risk

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

The service assessed and responded to patient risks. Leaders from each department in the hospital held a meeting each day at 9.30am which discussed the pressures, risks and staffing across the hospital. We saw this included consideration of outpatient activity including any additional risks within outpatients such as their minor procedure list.

Staff knew about patients with a medical history which represented an increased risk. Staff assessed patients before they attended for minor procedures as an outpatient. These assessments considered their medical history to identify any associated risk. Staff on the day of the procedure had access to these assessments and confirmed if the patient was still suitable for their procedure as an outpatient.

Staff ensured they considered the risks for each minor procedure. Staff completed a safety checklist before the start of minor procedures in line with the World Health Organisation's surgical safety checklist. This included; confirming the patient's identity, known allergies, and staff introductions to the patient. The minor procedure rooms were ventilated in line with national guidance. Having a well-ventilated room for procedures reduces the risk of spreading infections.

Tissue samples taken in the department were clearly labelled, recorded and checked with a colleague. This ensured patient's samples were tested correctly and prevented delays in results to inform the patients ongoing treatment plan.

Staff responded promptly to any sudden deterioration in a patient's health. Generally, acutely unwell patients would not attend the outpatients department. However, patients could still become acutely unwell while in the department and staff had training to care for these patients. Staff also took part in simulation training on resuscitation scenarios within the department. Staff had access to a resuscitation trolley. Staff told us if a patient became unwell in the department they assessed, monitored and cared for the patient. Staff said they received support from the resident medical officer, and they would consider the need for the patient to be admitted to the hospital ward or transfer to an NHS acute hospital.

Good

Outpatients

The hospital assigned staff across departments specific roles in the event of a cardiac arrest so on every shift there was a designated person to fulfil each role if a patient needed resuscitation.

Staff completed risk assessments for each patient during clinic appointments when needed. We saw patients being risk assessed for general anaesthesia, venous thromboembolism and allergic reactions to medicines. We looked at six patient records which when needed had risk assessments completed. Not all outpatient appointments would require the completion of risk assessments.

Staffing

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

There are no agreed national guidelines as to what constitutes 'safe' nurse staffing levels in outpatient departments.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. Clinical services in outpatients were supported by registered nurses and healthcare assistants. Staffing levels and skill mix for each day were planned by managers of the outpatients department based on the type and number of clinics running and the number of patients attending.

The manager could adjust staffing levels daily according to the needs of patients. Managers told us they moved staff from other departments to support safe staffing across the hospital. Staff told us they worked flexibly to meet the needs of their patients. Managers attended a hospital wide meeting at 9.30am to discuss staffing pressures in other departments. Staff worked flexibly across departments to ensure all areas had safe staffing levels.

The service had enough nursing and support staff to keep patients safe. Staff told us they had enough staff to keep patients safe. Patients said there were always enough staff to meet their needs. There were enough staff numbers in the physiotherapy department to cover the outpatient physiotherapy services. The service had enough reception staff to book in patients for their outpatients appointment. We saw there was not a long wait to speak with them even at busy periods.

The outpatients department had access to a range of medical consultants, who were granted practising privileges to provide an outpatient service at the hospital. Practicing privileges is a system of checks and agreements whereby doctors can practice in independent hospitals without being directly employed by them.

There was a resident medical officer on-site and when needed they provided medical support to outpatients. This included reviewing patients that had deteriorated during their outpatient appointment.

Managers limited their use of bank and only requested staff familiar with the service. The department did not use agency staff. Managers made sure all bank had a full induction and understood the service. Bank staff told us they had received a full induction that prepared them for their role.

The service had low vacancy rates. The hospital's vacancy rate for January 2022 was 8.9% which had increased from 4.9% in February 2021. Managers said this was in part due to them creating new posts to expand the services they offered.

Good

Outpatients

The service had low but increasing turnover rates. The hospital had a turnover rate of 11.8% in February 2021 which had increased to 17.1% by January 2022. However, in the outpatients department the staff we spoke to had been working for the hospital for several years and were happy with their employment. Some turnover included staff that were successful in taking up new posts following development opportunities.

The service had low sickness rates. The outpatients department over the past 12 months had an sickness rate of 6.7% for nursing staff and 1% for physiotherapy staff which included some absences caused by the pandemic.

Records

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

Patient notes were comprehensive and all staff could access them easily. Staff told us records were always easily accessible from their onsite medical records department. Staff said if any additional patient records were needed urgently, these were provided by the medical records department swiftly. We looked at six patient records which all had the relevant information within them including; medical history, risk assessments, observations, treatment plans, consent, and tests carried out. All entries in the records were legible, dated, and signed.

When patients transferred to a new team, there were no delays in staff accessing their records. The hospital had a record for each patient that was shared between the different departments in the hospital. This allowed staff in the other departments easy access to assessments carried out in outpatients. Staff in the outpatients department had access, without delays, to information on treatment and diagnostics carried out across the hospital.

Records were stored securely. Staff stored notes in locked drawers in clinic rooms or behind the reception desk in trolleys. The reception desk was always staffed and not accessible to patients or visitors which kept records secure from unauthorised access. Patient records were paper and were stored securely in the medical records department on site.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. We saw staff checked the patient's name, date of birth, and address before administering medicines.

Staff followed current national practice to check patients had the correct medicines. Staff received training in the management of medical gases which had a 100% compliance rate. Nursing staff received training on medicines management which had a 100% compliance rate. Staff completed medicines management audits for the outpatients department which showed 99% compliance in their last two audits. Actions noted following these audits were to continue monitoring, maintain their high level of compliance, and any incompliance were picked up and addressed immediately.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff explained medicine options including the risks and side effects to patients. Records showed staff reviewed patient's medicines at follow up appointments.

Staff completed medicines records accurately and kept them up-to-date. Medicine records in the outpatients department were clear and accurate.

Good

Outpatients

Staff stored and managed all medicines and prescribing documents safely. The department stored medicines in two rooms which were both temperature controlled. Records showed staff monitored the temperature in these rooms. The outpatients department did not store any medicines that needed refrigeration. Storing medicines at the correct temperature ensures they maintain their effectiveness. Staff prescribed medicines for privately funded patients on private prescriptions. Patients could either take these to the onsite pharmacy or take them to any external pharmacy. We saw these prescriptions included the patient's name, address, and their known allergies. The prescription pads were stored securely. Staff prescribed medicines for NHS funded patients on NHS prescriptions. These were stored securely with the serial numbers recorded in the attached logbook to ensure all prescription sheets were accounted for. Each prescription sheet had a unique serial number and staff recorded this, the patient's name and which consultant had issued it. This prevented unauthorised use of these prescriptions.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The hospital pharmacist and pharmacy manager received medicine safety alerts and shared these with staff when relevant to their practice. The pharmacy staff took the required actions from medicine safety alerts including checking medicines stored across the hospital for specific batch numbered medicines.

Incidents

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

Staff knew what incidents to report and how to report them. Staff knew how to access the service's incident reporting tool on their intranet. Staff told us they would ask their manager for support if they were unsure how to complete any parts of the form.

Staff raised concerns and reported incidents and near misses in line with provider policy. Staff were clear they needed to report all incidents including those that had not resulted in harm to patients. Staff in the outpatients department had reported 69 incidents in the past 12 months. The hospital had reported 403 incidents over the past 12 months with 325 rated as no harm, 75 as low harm, and three as moderate harm.

The department had no never events in the past 12 months.

The department had no serious incidents in the past 12 months.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Staff said they knew their responsibility to be open and honest with patients and relatives when things went wrong. They told us talking openly with patients when things had gone wrong helped their patients understand and allowed them to ask questions.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We looked at three incident records which all had detailed investigations. Managers had identified the root cause and additional learning to further improve patient care beyond the direct cause of these incidents. Staff had involved the patient in the investigation and provided wellbeing support for them.

Good

Outpatients

Staff received feedback from the investigation of incidents. Staff met to discuss the feedback and look at improvements to patient care. Staff received feedback on incidents in their department team meetings. Meeting minutes showed feedback and lessons learnt were shared in the last three team meetings. This feedback included ensuring changes in a patient's medical history are shared with their consultant to check if these would prevent the patient having surgery. This would prevent patients being cancelled on the day of their surgery.

There was evidence that changes had been made as a result of feedback. Staff were aware to check patient's height and weight at the first opportunity after a recent incident resulted in a patient being declined surgery as they were too high risk of deterioration due to a high body mass index. The hospital operated a 'stop the line' process, whereby any member of staff could stop activity if they encountered a situation that may cause patient harm. All staff were aware of this process and said they would enact it if they saw potentially unsafe clinical practice. During our inspection, there were two power cuts and staff called a 'stop the line' and held a 'swarm' meeting to discuss what improvements could be made to protect patient safety. Staff confirmed with the power company that there were going to be continued fluctuations with the service of power to the hospital until the next day. Staff agreed cancelling most activity including the minor procedures in outpatients due the risk of power loss during a procedure.

Are Outpatients effective?

Inspected but not rated

We do not rate effective.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We looked at policies related to outpatient care including; safeguarding vulnerable adults, complaints, mental capacity, deprivation of liberty and restrictive practice. These were up to date with consideration of national guidance from the Nursing and Midwifery Council, the Office of the Public Guardian, and the National Institute for Health and Care Excellence.

Leaders monitored national guidance and best practice changes which were reviewed in the monthly clinical governance meeting. We saw in these meetings minutes and team meeting minutes reminders for staff to read new policies.

Managers checked to make sure staff followed guidance. The service completed audits on compliance with their policies including consent, medicines management, and use of the surgical safety checklist. The last audit for consent in November 2021 showed 100% compliance and the last medicines management audit in January 2022 showed 98% compliance. The last audit for the surgical safety checklist in January 2022 showed 100% compliance.

Pain relief

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

Good

Outpatients

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Records showed staff monitored patient's pain levels at each visit to outpatients where this was relevant to the patient's treatment.

Patients received pain relief soon after requesting it. We saw NHS and private prescriptions given to patients by the department included all the required information including; the patients details, known allergies, the medicines name, dose, frequency and route. We saw staff administered local anaesthetic safely.

Staff prescribed, administered and recorded pain relief accurately. Local anaesthetic and paracetamol were stored in the department. Other pain relief medications were available via the pharmacy within the department. If patients were in severe pain, then they were admitted to the ward or to the local NHS trust for pain management and investigation into the cause.

Patient outcomes

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

There were no national audits relevant to this outpatients department.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers and staff used the results to maintain good patient outcomes. These audits included infection prevention and control, use of the surgical safety checklist, and medicines management. The last six months of audits showed high levels of compliance with the lowest being 97% for the use of the surgical safety checklist in December 2021 which then returned to 100% the following month.

Outcomes for patients were positive, consistent and met expectations. All patients reported their experience of the service as very good or good in six of the last 12 months with the lowest rate being 93% in August 2021. This showed patient's expectations were being met.

Managers shared and made sure staff understood information from the audits. Records showed audit results and learning points were shared with staff at their team meetings. This included reinforcing good practice seen in audits showing high compliance levels.

For our detailed findings on Patient outcomes, please see under this sub-heading in the surgery report.

Competent staff

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

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

Managers gave all new staff a full induction tailored to their role before they started work. All new staff completed an induction. Staff told us they had completed an induction which fully prepared them for their role.

Managers supported staff to develop through yearly, constructive appraisals of their work. Records showed all staff had completed an appraisal in the last 12 months.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us their appraisals were used to talk about how they wanted to develop their skills. Staff said they were supported in developing new skills to allow them to take on new roles. Managers were supportive of staff development and were keen to provide more services in the outpatients department.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff recorded what was discussed at these meetings and staff were able to access these records.

Managers made sure staff received any specialist training for their role. Managers kept records of competencies and supported staff to complete training and competency assessments to broaden their skill set.

Managers identified poor staff performance promptly and supported staff to improve. Staff told us if they needed support their managers were there to provide this for them.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. There was a daily meeting which was attended by a representative from all hospital departments. This meeting was held at 10.30am every morning with discussion on; patient numbers, staffing safety, housekeeping capacity, confirmation of safety check completion, fire safety, and staff wellbeing. This meeting also included discussion of agency staff, contractors and building work being carried out. This allowed all departments to know about any unfamiliar staff that are expected to be seen in the hospital. We saw this meeting on inspection and saw the meeting was carried out efficiently with a supportive culture including each department nominating staff members for recognition of demonstrating the service's values.

Staff told us they worked well with others within their own discipline and with staff from other disciplines. Staff said the collaborative working between nursing and medical staff had improved since the hospital changed to being run by Circle Health Group.

Patients could see multiple health professionals involved in their care during one visit to the hospital. Staff told us were possible they would arrange patient's diagnostic tests or physiotherapy sessions to coincide with their next outpatient appointment to limit the number of times patients needed to visit the hospital.

Seven-day services

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

The outpatient department did not provide an urgent or emergency service so was not open seven days a week. The outpatients department was open from 8am until 8:30pm Monday to Friday. The physiotherapy department was open from 9am until 5pm Monday to Friday, with extra opening hours in the morning and evening each day to allow patients that are unable to attend in these hours. The onsite pharmacy was open from 9am to 5pm Monday to Friday for outpatients to access.

Health promotion

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

Good

Outpatients

The service had relevant information promoting healthy lifestyles and support in patient areas. We saw information posters within the department. These included advice on chronic pain being reduced through regular exercise. The hospital's website had information on treatment options and simple explanations of why patients may benefit from these.

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle. Patients were offered advice or signposted to the relevant services to meet these needs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff could describe and knew how to access policy on Mental Capacity Act. The service had an up to date Mental Capacity Act policy. Staff told us they accessed policies on the intranet.

Staff received and kept up to date with training in the Mental Capacity Act and consent. Staff completed a mandatory training module in consent which had a compliance rate of 100%.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, and Mental Capacity Act 2005 and they knew who to contact for advice. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were able to describe how to assess a patient's capacity and knew they could ask for support from their manager if they were unsure.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. Managers audited the department's compliance with their consent policy with the last audit showing 100% compliance in November 2021.

Staff clearly recorded consent in the patients' records. Staff clearly recorded consent in patient records for minor procedures carried out in outpatients and for elective surgery to be carried out in the hospital as an inpatient.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Staff correctly confirmed consent with patients about to undergo minor procedures in the outpatients department.

Are Outpatients caring?

Good

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

Compassionate care

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

Good

Outpatients

Staff were discreet and responsive when caring for patients. Staff followed policy to keep patient care and treatment confidential. Clinic and treatment rooms had signs on the doors to indicate if the room was vacant or occupied. We saw staff using these signs when taking patients into rooms. Staff knocked and waited before entering closed doors. Reception staff were discreet when talking with patients to prevent their conversations being overheard by other patients.

Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff took time to explain treatment options and answer patients' questions. All staff we saw interacted in a respectful way with patients and their relatives. We saw a member of staff assist a patient to walk to the clinic room due to the patient's reduced mobility.

Patients said staff treated them well and with kindness. Patients and relatives told us staff were kind to them.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff told us when providing care for patients with mental health needs they provided personalised care without a judgemental attitude. They told us they would offer to talk with patients in a private room if they wanted to discuss their mental health needs.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff provided emotional support to their patients. Staff were passionate about putting the patient in the centre of their care and being there to support patients. The last audit by the Patient Led Assessments of the Care Environment (PLACE) showed privacy was 100% for the outpatients department which was 15% better than the national average for outpatients departments.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. Staff told us they took patients into a private room, sat with them to listen, provided emotional support and provided them with a quiet space if they preferred.

Staff understood how to break bad news and demonstrated empathy when having difficult conversations. Medical staff told us about how they showed empathy towards their patients when breaking bad news to them. Nursing staff said they would attend these conversations to provide additional support to patients. They said if patients had received bad news they would comfort and sit with them after their clinic appointment in a private room.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff understood they needed to provide emotional support to relatives as well as the patient.

Understanding and involvement of patients and those close to them

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

Good

Outpatients

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Patients told us staff communicated in a way they understood. Staff told us they used communication aids such as large print text, translation services, and signers.

Staff made sure patients and those close to them understood their care and treatment. Staff took time with patients and gave them opportunities to ask questions. We saw staff ensured a patient's clinic appointment did not start until the patient's husband had arrived as he was walking slowly due to reduced mobility and they provided support to the relative by walking with them to the clinic room.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service displayed information in the waiting area and in clinic rooms on how to provide feedback. The outpatients department collected patient feedback which was positive about the care received. All patients reported their experience of the service as very good or good in six of the last 12 months with the lowest rate being 93% in August 2021.Staff valued patient feedback and it was discussed at their daily hospital meeting at 9.30am.

Patients gave positive feedback about the service. We spoke to five patients and two relatives who all provided positive feedback about the way staff cared for them.

Staff supported patients to make informed decisions about their care. Patients told us they were provided with enough detail and time to make informed decisions about their care options.

Are Outpatients responsive?

Good

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

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the changing needs of the local population. Staff assessed the local need for services which had led to an increase in orthopaedic capacity due to a high level of demand from the local people.

The service relieved pressure on other services when they could treat patients. The service worked with local NHS service to treat NHS patients when the local NHS trusts were unable to keep up with needs of the local population. Managers told us they had increased their work for NHS trusts during the pandemic to meet the needs of local people as pressures had been higher on NHS trusts.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. Staff worked together to reduce the number of visits patients needed to make to the hospital while receiving all the services they needed. This included patients having their diagnostic or physiotherapy appointments before or after their outpatients appointments.

Good

Outpatients

Facilities and premises were appropriate for the services being delivered. The hospital had a dedicated outpatients entrance and reception area with two waiting areas. The department had 10 clinic rooms used by consultants to see patients with one set up for eye assessments. They had a treatment room for wound dressings and nursing interventions. The department had one minor procedure room with a recovery area next to it with space for two patients. The hospital had an onsite pharmacy that supplied medicines and sold toiletries, stamps and hearing aid batteries. The hospital had a car park with accessible spaces and a bus stop to link with local public transport. Patients told us there was not always enough parking spaces. Managers were aware of this and had taken actions to increase capacity including having staff park at local businesses to free up more space for patients.

The hospital's website listed the treatments and services available to patients and had details on how to contact the hospital to discuss services offered. Patients could book their initial appointment online or by calling the hospital's booking team. Their website also had details on risks of each treatment and an estimated cost to help patients plan. The outpatients department had a team to support patients that were self-funding to find an affordable way to pay for their treatment.

Managers ensured that patients who did not attend appointments were contacted. Staff contacted all patients that did not attend their appointment and rebooked them if the patient still required the appointment. Staff contacted patients about cancelled appointments to rebook them as soon as possible.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff told us how they supported patients living with a mental health condition. Staff said they comforted patients with anxiety in a private room. The service had easy read versions of their patient information leaflets for patients with a learning disability. These explained the information clearly with pictures and without using complex language. Staff told us about taking extra time to ensure patients with dementia understood the information provided to them. The hospital had a clear vision to support patients living with dementia which included posters reminding staff of ways to remain supportive to these patients.

The department was designed to meet the needs of patients living with dementia. The department had clear signs with bold, easy to read print and a plain coloured flooring. Flooring with multiple colours can appear to patients living with dementia as holes in the floor.

The service had facilities to meet the needs of patients with reduced mobility and patients using a wheelchair. The hospital had dedicated spaces for patients with a disability and step free access to the hospital. In the hospital, there were level floors with no steps between the entrance and the clinic rooms. The waiting areas had toilets which were accessible for wheelchair users.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service had access to large print patient information leaflets to ensure patients with limited vision were still able to access these resources. Throughout the department were signs informing patients that information was available in accessible formats.

The service had information leaflets available in languages spoken by the patients and local community. The service had patient information leaflets available in languages other than English including Cantonese and Portuguese.

Good

Outpatients

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us they had access to a telephone interpreting service, and this worked to ensure they had an interpreter for all patients that needed one. Staff said they would not use patients' relatives or friends as interpreters. This was in line with best practice. The service also had access to signers who they could book to be present in the department during the patient's appointment.

Access and flow

People could access the service when they needed it and received the right care promptly.

Managers monitored waiting times and made sure patients could access services when needed. Patients were referred to the outpatients department by their GP, by the NHS, and by self-referral. Patients could book appointments by phone or via the hospital's website. Patients were offered the most convenient appointment with their preferred consultant.

The outpatients department was open Monday to Friday. Consultants had regular slots when they held their clinics however if patients needed to attend on a different day the department arranged for them to see another consultant with the same speciality. The service did not provide an emergency service however, same day and next day appointments were arranged for patients when needed.

Reception staff greeted patients as they arrived in the hospital, checked them in on the hospital computer system and directed them to wait in the waiting area closest to the clinic room being used by their consultant. We saw patients were seen quickly after arriving at the hospital. On the day of our inspection, the outpatients department was calm and well organised even at busy times .

Managers monitored waiting times and made sure patients could access services when needed. The service completed waiting time audits for the outpatient department. Managers used this to identify areas for improvement including consultant clinics that were consistently running late. We saw an action plan to address these late running clinics. Managers made the first appointment slot later for clinics that consistently started late and increased the duration of clinics that struggled to fit all their patients into the time to spread out patient appointments. Reception staff told patients on their arrival if their consultant was running late and delays were displayed in the waiting area.

Managers worked to keep the number of cancelled appointments and treatments to a minimum. Managers monitored the amount of patients not attending and cancelling appointments. The department had a low rate of patients not attending for follow up appointments. Data showed the numbers were better than their target every month for the past 12 months. Data showed the number of patients not attending for their initial appointment was better than their target in 11 of the past 12 months. Managers explained 7.7% of patients did not attend in October 2021 which exceeded their threshold of 5%. They saw an increase in the number of patients not attending due to patients contracting COVID-19.

When patients had their appointments or treatments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. Staff contacted and rebooked patients that had their procedures cancelled. Staff tried to be flexible to the patient's needs while arranging to rebook these patients without excessive delays.

Staff arranged for patients requiring follow up appointments to be supported to book these before leaving the department. Staff arranged, where possible, for outpatients appointments, physiotherapy sessions, and diagnostic tests to be completed on the same day to reduce the number of times patients needed to travel to the hospital.

Good

Outpatients

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. Patients and relatives told us they knew how to raise a complaint.

The service clearly displayed information about how to raise a concern in patient areas. The department displayed information on how to raise a concern or complaint. The service had received 22 complaints in the past 12 months.

Staff understood the policy on complaints and knew how to handle them. Staff told us they tried to address complaints or concerns immediately to see if they could be solved straight away. Staff said if they were unable to resolve the patient's concerns then they would get support from senior managers and provide information on how to raise a complaint.

Managers investigated complaints and identified themes. We looked at five complaints related to outpatients all of which had a detailed investigation. We saw meeting minutes showing managers discussed themes of complaints.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We looked at five complaints and all had received an acknowledgement within one day of being received. All these complainants had received a response addressing all points raised.

Managers shared feedback from complaints with staff and learning was used to improve the service. We saw in meeting minutes learning was shared including reminders of the importance of checking a patient's weight and height during appointments in the run up to planning surgery. This was due to the hospital not performing surgery on patients with a body mass index over 40 as a result of the increased risk of deterioration.

Staff could give examples of how they used patient feedback to improve daily practice. Staff said learning was shared with them in their team meetings. They told us about ensuring clear communication with patients about the costs related to their treatment options.

Are Outpatients well-led?

Good

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

Leadership

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

Good

Outpatients

The service had a clear leadership structure for the outpatients department. The daily running of the service was led by a nursing sister that had worked for the hospital for many years and had extensive experience in outpatients. The department was led by a manager shared with the diagnostic services while the outpatients manager was on a year of leave. They reported to the registered manager that led the hospital and were supported by senior managers.

Leaders understood the challenges the department faced and led improvements. Staff spoke highly of their manager at all levels and described them as visible, approachable, and knowledgeable.

Leaders supported staff to develop their skills and take on more senior roles. Staff told us how they were supported to develop their skills. Staff were supported to develop their leadership skill with an introduction to leadership course available to all levels of staff.

Vision and Strategy

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

The hospital had a clear purpose statement which was 'To provide the high quality, safe and compassionate care our patients need and expect.'

The service had a vision for what it wanted to achieve. The hospitals vision was 'to be recognised as outstanding by our patients, our staff and our regulator.'

The hospital had four key principles to help them achieve their purpose. The key principles had quality and sustainability amongst their priorities. Underpinning their principles were eight values for all staff to demonstrate. These include "collaborative and committed" and "agile and brave".

We saw staff provided care in line with these values. Staff were involved in discussions to shape the vision and strategy for the hospital.

The service had a clinical strategy to turn their vision into action. Staff had developed a strategy for The Chaucer Hospital which included practical advice and methods to be used in achieving their vision.

Leaders monitored their progress against their strategy. Managers met to review progress against their strategy monthly. We looked at this strategy and could see actions were achieved. These included a recognition that 'senior managers needed to listen more' which staff told us they were doing. The provider told us that heads of department attended a quarterly strategy day to engage them in the strategy.

Culture

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

Staff felt respected, supported and valued. Staff said they felt leaders and other staff respected them. They told us they felt valued by staff in their department and by staff from across the whole hospital. The 2021 staff survey showed more staff felt valued than did not. Staff were focused on the needs of patients receiving care. Staff told us they put their patients' needs at the centre of all they did. We saw staff worked together to meet the needs of their patients. Staff were welcoming and professional in communication with their patients and each other.

The service promoted equality and diversity in daily work and provided opportunities for career development. The 2021 staff survey showed some people felt limited by the opportunities for career development, however staff told us this had improved with more support being offered. Staff completed equality and diversity training with a compliance rate of 99.4%.

The service had an open culture where patients, their families and staff could raise concerns without fear. Staff said they raised concerns, and these were viewed as opportunities to improve the service. We saw reminders from leaders to report incidents and raise concerns with the aim of improving the service and maintaining patient safety.

The hospital had recently been accredited with the workplace well-being charter. The accreditation was for organisations who were committed to improving the health and well-being of their workforce. The hospital had a notice board for wellbeing at the front of the hospital which showed what the hospital was doing to promote wellbeing and how they support staff.

There was a strong emphasis on the safety and wellbeing of staff; for example, the hospital was accredited with a recognised workplace wellbeing award. This demonstrated the hospital's commitment to the health and wellbeing of their staff.

Governance

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

Leaders operated effective governance processes, throughout the service and with partner organisations. The hospital followed the Circle Health Group corporate governance assurance framework. This set out how the hospital structured their governance arrangements from the outpatients department in the hospital to board at Circle Health Group.

The service held meetings to discuss and learn from the performance of the service. Clinical heads of departments held a monthly clinical governance committee meeting which included discussion of learning from incidents, safety alerts, patient feedback and audits. Information for escalation from the clinical governance committee fed into the hospital's managers then up to the Circle Health Group regional team.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff in outpatients were clear about their roles and understood what they were accountable for, and to whom. They held monthly team meetings which included discussion on learning from incidents and sharing of information from the hospital's committee meetings.

The hospital had the following regular committee's: health and safety, medicines management, infection prevention and medical advisory committee. These fed into the clinical governance committee. Meeting minutes from the last year were clear and comprehensive.

Good

Outpatients

Staff held a daily meeting which was attended by a representative from all hospital departments. Staff at this meeting discussed; patient numbers, staffing safety, housekeeping capacity, confirmation of safety check completion, fire safety, and staff wellbeing. Staff received a summary of the information discussed in a daily email and a staff daily communication flyer was put on the department's noticeboard.

Management of risk, issues and performance

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

Leaders and teams used systems to manage performance effectively. They shared performance information with staff via notice boards at the nurse's station and via team meetings. Staff said their electronic system to report and update risks was easy to use and available to everyone to enter risks.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Leaders kept an up to date risk register with mitigating actions recorded against each risk. The registered manager and the health and safety lead discussed the full risk register monthly and the top risks were discussed at the clinical governance committee and the safety, health and environment meeting. The top five risks were discussed in the outpatients meetings and displayed on posters at the nurse's station. However, not all staff we spoke with knew these top five risks but did know about ones most relevant to their department.

The service had plans to cope with unexpected events. We saw staff efficiently and safely manage an electrical power failure during our inspection.

Staff were not constrained by financial pressures from delivering safe care and quality improvements. Staff told us they were not discouraged from pursuing improvement to safety or quality by financial pressures. Staff told us since being part of the Circle Health Group they had received new and additional equipment to help improve patient safety and experience in the outpatients department.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

The service collected reliable data and analysed it. Staff and leaders collected and analysed data on staffing, quality and safety. This included monitoring of compliance with; surgical safety checklist, hand hygiene, use of personal protective equipment and medicines management.

The information systems were integrated and secure. Most records were paper which were kept in locked clinic rooms or behind the reception desk that was always staffed. Electronic records and digital information were kept on computers that were secured with usernames and passwords for each member of staff preventing unauthorised access. Staff logged out of computers when not in use. The hospital had an information security officer and a Caldicott officer.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Staff told us information was displayed clearly and was easily accessible. Leaders monitored the waiting time for outpatient appointments and had identified long waits for gynaecology and gastroenterology surgery. Leaders were trying to attract more consultants to provide additional clinic capacity and they had recently been joined by another consultant gastroenterologist.

Engagement

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

Leaders and staff actively and openly engaged with patients. Staff collected feedback from patients and leaders analysed this for trends which was then shared with staff. The service had a monthly half day meeting to bring the team together to review performance data and discuss patient feedback. As part of this half day the team had a specific outpatients department meeting. Their purpose was to update teams on operations and share learning.

Leaders discussed patient feedback at their monthly clinical governance committee. We saw in the January 2022 clinical governance committee meeting minutes that they discussed why patients had declined to attend their appointment. The Chaucer Hospital had agreed to ask their reservations team to request details on reasons patients were declining care to focus improvement.

Leaders engaged with staff. The service carried out a yearly staff survey to understand the feelings of their staff with 73% of staff responding to the survey in March 2021. This showed over 70% of staff that responded felt their manager cared about them as an individual. Staff told us their managers engaged well with them and recognised their contributions. Staff told us about gifts they received from the provider and the leaders in their hospital at Christmas and Easter. Senior managers ran a monthly ‘time to come along and have a cup of tea and a cake’ with the senior managers whilst discussing concerns with them.

The hospital executive director formally engaged with staff regularly, through a team brief which they emailed to staff. This outlined key messages for staff such as the hospital’s vision and strategy and wellbeing strategies and support.

The service engaged with the public and local organisations. Staff had donated gifts for Christmas and raised awareness for a local charity that helped homeless people. Staff from the local commissioning group and NHS acute trust provided positive feedback about The Chaucer Hospital’s engagement and responsiveness to the needs of local people.

Leaders and staff engaged with equality groups. Staff worked with local charity groups to raise awareness and funds for their work. Staff had held a charity bake off raising money for a local mental health support charity. The service carried out an assessment of the workforce race equality standards each year. We looked at their report from March 2020 which showed they had made some improvements in reducing harassment and discrimination of people from a Black, Asian or minority ethnic groups. Leaders acknowledge there is still more to do, and they created an action plan to work towards more engagement and inclusion.

The service engaged with patients living with dementia. The service had supported 70 of their staff to become Dementia Friends and the service had linked in with to local Dementia friend's community.

Good

Outpatients

Learning, continuous improvement and innovation

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

Staff and leaders were committed to continually learning and improving services. Leaders used information to improve care. Staff were passionate and committed to continuous improvement. Staff and leaders told us they saw concerns, complaints and incidents as an opportunity to make their service better.

The service recognised and rewarded staff for innovations and quality improvements. The service recognised ideas from staff with 'you said, we did' posters displaying ideas and the actions taken by staff to address them. This included a desire to improve the ways the service protected our environment. Staff had nominated a green guardian to promote recycling. We saw clear guidance on segregating recyclable waste and staff following this by putting suitable nonclinical waste in designated recycling bins. Staff nominated each other and were nominated by their managers for demonstrating the services values or beliefs in going above and beyond. These are then discussed at the leadership meeting to choose a winner each month that received a bottle of champagne and have their photo displayed with a description of what they had done. The runners up all received a letter from the registered manager thanking them.

Good

Diagnostic imaging

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

Are Diagnostic imaging safe?

Good

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

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. The service provided mandatory training in key skills for administration staff, imaging healthcare assistants and radiographers. All staff were up-to-date with their mandatory training. Staff said they had protected time to complete mandatory training. Where bank staff worked at other healthcare providers, the service ensured they received evidence of completion of mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff. The service provided a mixture of online and classroom sessions for mandatory training. Staff received training aligned to the Core Skills Training Framework outlined by Skills for Health. Staff said mandatory training met the needs of their role. All staff completed specific radiation protection training and radiographers had received specific training in medicines management and aseptic non-touch technique.

Staff completed training on recognising and responding to patients with dementia. Staff completed dementia awareness as part of their mandatory training. All staff were up to date with their training. The service had notice boards in staff areas to remind them about communication methods for patients with dementia. The hospital had a campaign to train staff to be dementia champions.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers monitored mandatory training compliance. The online mandatory training system sent staff an email to alert them when mandatory training was due. Mandatory training compliance was discussed during the imaging department monthly meeting.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Good

Diagnostic imaging

Staff received training specific for their role on how to recognise and report abuse. All staff were up-to-date with safeguarding mandatory training. Staff had the appropriate level of safeguarding adults and safeguarding children training in line with intercollegiate guidance. The clinical services manager for the imaging department was trained to level 3 safeguarding for adults and children. Staff demonstrated a good understanding of safeguarding and their responsibilities around safeguarding.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. The hospital had a safeguarding vulnerable adults and safeguarding children and young people policy. These outlined what staff should do when they had safeguarding concerns. These policies gave information on groups at risk of specific safeguarding concerns. The policy also outlined staff responsibilities in relation to female genital mutilation, how to report it and what agencies to work with.

Staff knew who to inform if they had concerns. Staff demonstrated a good understanding of who to escalate safeguarding concerns to. The hospital had a safeguarding lead and all staff we spoke to knew who this was.

The service displayed posters throughout the department which informed patients that they could ask the receptionist if they would like to speak to a member of staff in private. This was a way for patients to raise concerns.

Staff followed safe procedures for children visiting the service. The service did not provide imaging to children and young people. If a patient arrived for their appointment with a child or young person the service would rebook the appointment. This was to ensure safety of the child or young person as they could not enter the room while imaging scans were being done and could not wait in the waiting area alone.

The director of clinical services and the quality and risk manager attended regular regional safeguarding meetings with other Circle Health Group hospitals to discuss safeguarding themes and learning from safeguarding incidents.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They generally kept equipment and the premises visibly clean. However, the MRI scanner had a significant layer of dust on it.

Generally clinical areas were clean and had suitable furnishings which were clean and well-maintained. Clinical areas were visibly clean and clutter free. Furnishings were wipe clean and intact with no damage.

The service generally performed well for cleanliness. The service participated in patient-led assessments of the care environment. The service scored 100% for cleanliness in this audit. The service completed infection prevention and control audits every two months. These audits monitored staff compliance with personal protective equipment use, sharps storage and disposal. The imaging department had scored 100% in the five most recent audits. The service attended quarterly hospital infection prevention and control meetings.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Housekeeping staff kept the waiting areas and corridors clean. Clinical staff were responsible for ensuring clinical areas were clean. All cleaning records were complete and up-to-date. The service completed monthly cleaning audits. Results from these audits demonstrated good compliance.

Staff followed infection control principles including the use of personal protective equipment (PPE). All staff wore appropriate PPE for the care they were giving. All clinical staff were bare below the elbows and cleaned hands between

patient contact. The service completed hand hygiene audits every two months. Results from these audits demonstrated good compliance with hand hygiene. The service managed COVID-19 infection prevention and control measures well. All staff and patients wore fluid resistant disposable face masks and staff actively encouraged and challenged social distancing when it was not being adhered to.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw staff clean equipment after patient contact. The service used "I am clean" stickers to indicate when equipment was last cleaned. The service completed regular audits to monitor staff compliance with cleaning patient equipment. The imaging department had scored 100% in the most recent five audits. However, the MRI scanner had a significant layer of dust on the bore surround.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, the x-ray door was not always locked when radiation was in use.

The design of the environment followed national guidance. The environment layout was in line with health building notes best practice guidance. For example, each clinical room had a hand basin sink with a long lever tap to enable efficient hand hygiene. The service had relevant risk assessment documents for each area of the department. For example, the temporary x-ray room had a risk assessment which outlined the potential risk of radiation in the environment to patients and staff. This risk assessment included engineering controls to mitigate the risk.

Where radiation was being used, "radiation controlled area" lights and signs were present. Access to rooms where radiation is in use was restricted, to ensure patients could not accidentally enter. However, in the temporary x-ray room the door had signs but did not have a light to warn staff when radiation was in use. The local policy was to lock the door when radiation was in use. We saw staff did not always follow this policy.

Staff who used radiation wore personal radiation monitors to record their level of occupation exposure to radiation. The service monitored the level of occupation exposure of radiation to staff.

The service carried out a radiation physics departmental audit. This was aligned to Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R). No concerns were identified in the most recent audit.

Staff carried out daily safety checks of specialist equipment. The service completed monthly quality assurance checks on imaging equipment. Records for quality assurance checks were up-to-date and complete. The service had evidence of regular quality assurance checks completed by medical physicists from the local NHS trust. The service shared resuscitation equipment with the outpatients department, please see this section of the outpatients report for our findings.

The service had enough suitable equipment to help them to safely care for patients. The service had an x-ray, ultrasound, CT and MRI machines. Equipment was routinely tested and had stickers on with the last service date. The service had an agreement with an external provider to maintain imaging equipment and the mobile MRI and CT scanner units. All equipment was within its yearly maintenance. All clinical staff had received training on use of equipment. All portable electrical equipment had received safety testing.

Staff disposed of clinical waste safely. Waste was segregated with separate colour coded arrangements for general waste and clinical waste. Sharps, such as needles, were disposed of in line with national guidance.

The hospital had an independent fire safety risk assessment. This assessment did not identify any concerns. The service completed a fire risk assessment review of the department, which was updated annually. The service had fire exit signs clearly displayed. All fire extinguishers were labelled and in date. All fire exits and doors were kept clear and free from obstruction. All staff completed mandatory fire safety training and all staff were up to date with this.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. However, patient safety information was not always complete on patient referral forms for MRI scans.

Staff responded promptly to any sudden deterioration in a patient's health. Staff demonstrated they understood the process to manage medical emergencies in the department. Administration staff had emergency numbers which they would call in an emergency. The service had emergency evacuation procedures displayed in each area of the department. Staff demonstrated how they had recently followed the emergency procedure when a patient collapsed in the mobile unit. Staff evacuated the patient successfully and the patient was transferred to the local accident and emergency department. The mobile units had telephones and a back-up two way radio system to use in emergency situations.

Staff knew about and dealt with any specific risk issues. The service had an established process to ensure the correct person was receiving the correct scan. Staff went through a 'pause and check' checklist with each patient to confirm the patient's name, address and body part for the scan. This is in line with legal requirements of Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R), to prevent radiation exposure to the wrong patient. We saw staff using the 'pause and check' process.

Staff completed risk assessments for each patient. Imaging requests generally included relevant information to keep patients safe. However, we found all four MRI referrals we reviewed did not have relevant safety information to keep patients safe. This included general patient safety information such as health conditions and MRI specific patient information. We found that relevant patient safety checks were completed by radiographers at the time of the appointment. However, this was a missed opportunity to identity risk.

The service had a pregnancy check procedure. Patients completed a pregnancy check consent form with staff. These forms were non-gender specific which is best practice in terms of diversity and inclusion. The service had pregnancy check notices in the waiting room and each clinical room, this was to prompt women who are or may be pregnant to inform staff before exposure to radiation.

The service had a named radiation protection supervisor and a named radiation protection advisor to access for advice. Staff were aware of who these individuals were.

The service displayed local rules in areas where medical radiation was being used, as required by the Health and Safety Executive who regulate IR(ME)R Regulations. The local rules included a framework of instructions for staff to follow.

The service had diagnostic reference levels for staff to use. Diagnostic reference levels are a benchmark for patient radiation dose where certain variables (such as equipment and patient size) are standardised. This is in line with legal requirements of IR(ME)R.

Staff shared key information to keep patients safe when handing over their care to others. When a patient was having an inpatient scan following an operation, staff ensured relevant information was handed over when necessary.

Good

Diagnostic imaging

Staffing

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

The service had enough staff to keep patients safe. The service had two lead radiographers, six senior radiographers, two imaging healthcare assistants and four imaging administrators. Staffing levels were discussed during the hospital's morning meeting, where the clinical services manager for imaging had to confirm that staffing was safe. Staffing was also discussed during monthly team meetings. Managers said they would cancel appointments if there were unsafe staffing levels.

Managers accurately calculated and reviewed the number of staff needed for each shift in accordance with national guidance. The manager could adjust staffing levels daily according to the needs of patients. The manager reviewed the clinics planned staffing levels for each week and adjusted the number of staff based on the number of clinics and the demand from theatres and the ward areas of the hospital. This service considered the risk to patients in each modality. For example, for a patient list for MRI the service allocated two radiographers. Alternatively, for a CT cardiac list the service allocated two radiographers, one imaging healthcare assistant, one radiologist and one cardiac consultant. The service ensured staffing levels meant there is no lone working.

The service had an on-call rota during evenings and weekends. This was to provide cover if inpatients required an urgent scan. The service had an agency resident medical officer on site when the service had patients requiring contrast for diagnostic imaging.

The service had low vacancy, turnover and sickness rates. The hospital's vacancy rate for January 2022 was 8.9% which had increased from 4.9% in February 2021. Managers said this was in part due to them creating new posts to expand the services they offered. The service had low vacancy rates and the service had vacancies for bank radiographers only. The sickness rate for the department was 6.5% in the last year. The hospital had a turnover rate of 11.8% in February 2021 which had increased to 17.1% by January 2022.

The service had low rates of bank staff. Managers limited their use of bank staff and requested staff familiar with the service. The service had three named bank radiographers. These individuals were used to cover shifts regularly and therefore they were familiar with how the service ran. The service did not use agency staff.

Managers made sure all bank staff had a full induction and understood the service. Bank staff had the same induction as permanent staff. This included an induction pack tailored to imaging services, with relevant health and safety information and competency checklists for new starters to complete.

Records

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

Patient notes were comprehensive and all staff could access them easily. The service used some paper records such as, consent forms which patients had to sign. We reviewed five sets of patient records. These were comprehensive and clear. The service participated in a hospital-wide audit of patient records. This audit reviewed compliance of records security and completeness. The hospital wide compliance from the most recent audit was 96%.

Good

Diagnostic imaging

When patients transferred to a new team, there were no delays in staff accessing their records. The service recorded patient notes on an electronic system, this meant that when patients transferred between departments in the service, there were no delays in staff accessing their records as all staff could view the records on the system.

Records were stored securely. Diagnostic imaging records were stored and accessed on an electronic system. Records were stored securely as the electronic systems were protected with individual passwords. The service completed a yearly audit of their patient record management systems. The compliance from the most recent audit in January 2022 was 100%.

The service had a process for non-medically qualified referrers and a scope of entitlement which outlined what they could refer patients for. Referring clinicians had access to the Royal College of Radiologist referral guidelines to help them request the safest and most valuable imaging scans. Referral requests were authorised by a radiologist.

Medicines

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

Staff followed systems and processes to administer medicines safely. Staff stored and managed all medicines safely. Staff completed medicines management as part of their mandatory training to administer contrast medicines. All staff were up-to-date with this training. Medicines were stored in either locked cupboards, fridges or warmers. Fridge and warmer temperature checks were completed, with no alerts that the fridge temperature was outside of the normal range. The hospital had a pharmacy team who checked medicines stock regularly to ensure medicines were in date.

Staff completed medicines records accurately and kept them up-to-date. The service administered contrast medicines for specific scans. Contrast medicines used were recorded in patient notes. The service did not keep controlled drugs. Medicines were stored securely and were all in date.

Staff learned from safety alerts and incidents to improve practice. The service completed a regular medicines management audit. The audit showed good compliance with medicines management in the last six months. Medicines management incidents and learning were discussed during the clinical governance committee meeting. The service had zero medicines incidents in the last year.

The hospital pharmacist and pharmacy manager received medicine safety alerts and shared these with staff when relevant to their practice. The pharmacy staff took the required actions from medicine safety alerts including checking medicines stored across the hospital for specific batch numbered medicines.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents, serious incidents and near misses in line with service's policy. The service had an incident management policy. This outlined staff responsibilities around incidents and how to report them. Staff understood how to report incidents and had a good reporting culture. Staff felt able to raise incidents and concerns.

Good

Diagnostic imaging

The hospital operated a “Stop the Line” process, whereby any member of staff could stop activity if they encounter a situation that may cause harm. All staff were aware of this process and said they would use it if they saw potentially unsafe clinical practice.

The service had reported 52 incidents in the last year. There were no themes to these incidents. The service reported no IR(ME)R reportable incidents in the last year.

Staff knew how to report serious incidents clearly and in line with the service's policy. Staff demonstrated how they would report a serious incident. The service reported no serious incidents in the last year.

The service had no never events. The service reported no never events in the last year. A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at national level, and should have been implemented by all healthcare providers. They have the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. The hospital had a “Being Open and Duty of Candour” policy. Staff gave a recent example of carrying out their duty in line with this policy. There was an incident where a patient received an x-ray scan instead of their intended ultrasound. Staff apologised to the patient when they realised the mistake in line with hospital policy. The service had no requirement to use duty of candour as part of a serious incident investigation in the last year.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. Incidents were discussed during monthly imaging department team meetings. Learning from both imaging incidents and hospital wide incidents were discussed as a team and actions developed to implement learning. Actions were followed-up at the next team meeting.

There was evidence that changes had been made as a result of feedback. The service had recent learning from an incident. A patient fell when mobilising to the toilet following arrival back to the ward after an imaging appointment. The service participated in a hospital “swarm” meeting to determine what improvements could be made to prevent this happening again. Staff agreed porters were to take patients between the ward and imaging department to ensure safe handovers. Staff reported this was working well.

Are Diagnostic imaging effective?

Inspected but not rated

We do not rate effective.

Evidence-based care and treatment

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

Good

Diagnostic imaging

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service monitored the latest guidance to ensure policies and procedures were up-to-date. The service completed regular audits to monitor staff compliance with the latest guidance. These included: clinical practice, documentation and quality, governance and compliance. The service demonstrated compliance based on its audit results completed in the last year.

The service monitored results from clinical audits against performance of other hospitals in the Circle Health Group. Benchmarking their results against other hospitals meant the service could see where they were performing well and where there could be improvement. The service was performing well against the score for all hospitals in Circle Health Group.

The service monitored radiation doses to ensure doses were kept as low as reasonably possible. The service completed a yearly audit of patient doses against local and national diagnostic reference levels for all types of imaging. The results from these audits demonstrated patient doses were lower than diagnostic reference levels.

All of the service's policies were current, version controlled and reflected national guidance.

Pain relief

The service did not give pain relief.

Staff did not give pain relief as patients were in the imaging department for a short period of time.

Pain relief was managed by the ward if the patient was receiving a post-procedure diagnostic scan. A physiotherapist would often bring this type of patient from the ward for their scan to assist with moving the patient appropriately for their pain.

Pain was managed by consultants and the patient if the scan was part of an outpatient consultation or investigation.

Patient outcomes

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

The service participated in relevant national audits. Outcomes for patients were positive, consistent and met expectations. The service submitted data to the Private Healthcare Information Network (PHIN), for benchmarking against other independent providers. PHIN is an independent source of information about private healthcare, aiming to enable patients to make better-informed choices of care provider. Outcomes for patients were positive and as expected.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Improvement is checked and monitored. Managers used information from the audits to improve care and treatment. The service completed regular audits such as medicines, clinical practice, documentation and quality and World Health Organisation surgical safety checklists. The service had good results from its audits completed in the last year. If the audit identified improvements, an action plan was developed and monitored.

Managers shared and made sure staff understood information from the audits. Managers and staff used the results to improve patients' outcomes. Audit results were discussed during the monthly team meeting. This gave staff an opportunity to understand the results. Managers and staff discussed ways to improve the patient experience and outcomes during these meetings.

Good

Diagnostic imaging

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff received regular mandatory and additional training to ensure they had the right skills and knowledge to keep patients safe. Staff completed competency checks during induction, and every two years. Staff underwent a cannula insertion peer review which meant another member of staff watched them cannulate different patients ten times over the year.

Managers made sure staff received any specialist training for their role. Staff received specialist training for their role. Radiographers had received specific training in medicines management and aseptic non-touch technique to ensure safe administration of contrast during scans.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers supported staff to develop through yearly, constructive appraisals of their work. All staff had a yearly appraisal with their manager. Managers identified training and development opportunities and discussed these during appraisals. Staff were supported to develop their skills and knowledge. The service had secured funding to train two imaging healthcare assistants to be radiographers.

Staff had the opportunity to discuss training needs with their line manager. Training was discussed during the monthly imaging department meeting. This allowed time for staff to ask for additional training.

Managers gave all new staff a full induction tailored to their role before they started work. All new staff completed an induction. This was detailed in an induction pack tailored to imaging services, with relevant health and safety information and competency checklists for new starters to complete.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff were given protected time to attend the monthly imaging department meeting. If staff could not attend, they had access to the formal meeting minutes.

Multidisciplinary working

Staff worked together as a team to benefit patients. They supported each other to provide good care.

The service did not run multidisciplinary meetings. Multidisciplinary meetings occurred at the patient's local NHS trust to discuss patients and improve their care.

The service aimed for patients to see all the health professionals involved in their care. The service did not currently offer "one-stop" clinics for patients. However, staff aimed to book imaging appointments on the same day as outpatient appointments if they were able to. The clinical services manager for imaging had an ambition that "one-stop" clinics would be set up following completion of the services imaging project.

Staff worked across health care disciplines and with other agencies when required to care for patients. The service worked well with other departments in the hospital to provide an imaging service for outpatient appointments and inpatient stays. The service worked with local healthcare providers who were currently supporting their mammography service during their imaging project to upgrade their department.

Good

Diagnostic imaging

Seven-day services

Key services were available to support timely patient care.

Diagnostic imaging services were available seven days a week. The service ran scheduled appointments. CT scans ran between 8am to 8pm Tuesday, Wednesday and Thursday. The service ran an on-call rota for urgent out of hours scan requests for inpatients on the wards.

Health promotion

Staff gave patients practical support and advice around safety of radiological scans. The service promoted healthy lifestyles and support to patients.

The service had posters and information packs in the waiting area of the department. These displayed relevant information about health and safety associated with radiation and diagnostic scans. These prompted patients to ask staff for support if they had any questions.

The service had information promoting healthy lifestyles and support in patient areas. The provider told us they had information to support patients to lead healthier lives in line with national priorities such as smoking cessation and obesity in the waiting area for pre-operative assessment, which was shared with the diagnostic imaging waiting area.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards. The hospital had a "Mental Capacity, Deprivation of Liberty and Restrictive Practice" policy. This policy outlined responsibilities of staff and what to do when they had concerns about a patient's capacity. Staff could access this policy. The service had not made any applications to deprive a person of their liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff demonstrated a good understanding of capacity and described what the process was if they felt a patient lacked capacity at the time of their imaging appointment. They stated they would contact the clinical services manager for imaging for advice.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. Staff received mandatory training on consent. All staff were up-to-date with this training. Staff made sure patients had all information available before a scan. The waiting area had information about different radiological scans for patients. Staff gained consent before completing a scan and this was recorded.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff received Mental Capacity Act and Deprivation of Liberty Safeguards training as part of their level two safeguarding adults training. All staff were up-to-date with this training.

Are Diagnostic imaging caring?

Good

Diagnostic imaging

Good

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

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw staff treat patients and their relatives in a kind, compassionate and respectful way. Staff treated patients with dignity and respect. For example, staff covered patients with a blanket during imaging to protect their dignity. The service had dignity champions. The service displayed posters throughout the department which informed patients that they could ask the receptionist if they would like to speak to a member of staff in private.

Patients said staff treated them well and with kindness. Patients were overwhelmingly positive about the service and staff in the imaging department. One patient said “Good staff, very efficient and polite.” The service collected patient feedback. This feedback showed that between 93% to 100% of patients agreed that their overall experience of the imaging department was “very good” or “good”.

Staff followed policy to keep patient care and treatment confidential. Staff maintained patient confidentiality. Staff closed consulting room doors during patient care to protect the privacy and dignity of patients. Staff knocked and asked permission before entering a room. Patients were able to speak to receptionists without being overheard. The service participated in patient-led assessments of the care environment (PLACE) audits. The service scored 100% for privacy in this audit.

The service had a chaperone process. The service displayed posters throughout the department to advertise patients right to a chaperone.

Emotional support

Staff provided emotional support to patients to minimise their distress. They understood patients' personal needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff gave emotional support whilst caring for patients and were allowed time to provide additional emotional support to patients when needed. The service gave patients information leaflets about their diagnostic scans. This gave patients support and information regarding care before, during and after their scans. This included emergency numbers to call if they had a concern.

Staff understood and respected the personal and social needs of patients and how they may relate to care needs. The service received feedback from patients about how the environment supported those with learning disabilities and dementia as part of their PLACE audit. The service performed well in these areas of the audit. Staff received training in communication for patients with dementia. The hospital had pledged to become a carer friendly hospital, recognising that some of their patients, relatives of patients and staff may be carers.

Good

Diagnostic imaging

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Patients described knowing who they would contact following a scan if they had concerns. Patients described knowing when their next appointment would be and how they would receive information regarding it.

For patients who self-funded for their imaging scans, the service was transparent about pricing. This enabled patients to make informed decisions about their treatment.

Staff talked with patients in a way they could understand. Patients we spoke with told us they understood their care and treatment and staff spoke with them in a way they could understand. The service identified patients who required additional communication support. The service organised support such as interpreters to ensure patients could understand.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service. Patients completed paper-based surveys to feedback about the service. These were readily available and accessible to all patients as they were in the waiting area. Staff also received patient feedback verbally and through the complaints process. Latest patient satisfaction survey results demonstrated positive feedback from patients. Patient feedback was overwhelmingly positive, complimenting staff, the environment and the service.

Are Diagnostic imaging responsive?

Good

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

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Managers planned and organised services so they met the changing needs of the local population. The service organised and managed imaging appointments based on patient and referring clinician demand. Patients were offered a choice of imaging appointments. The service offered evening and weekend appointments to support patients.

Facilities and premises were appropriate for the services being delivered. The environment was appropriate, and patient centred. It was clearly signposted and easy to find. It had a car park, plenty of seating in the waiting area and water machines for patient and relative use. Toilet facilities were clean and accessible for all. The service was on the ground floor and the environment was accessible by wheelchair.

The service relieved pressure on other departments. When needed, the service provided timely imaging scans for patients on the inpatient wards. This supported patient recovery and discharge.

Good

Diagnostic imaging

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff identified if a patient required additional support to meet their needs. Staff recorded this on the service's patient management system. This meant all staff were aware of any additional needs to support their patients. Additional needs include patients who English is not their first language. They may need additional support such as a translator.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service had "Your Information, Your Way" posters in the waiting area. This advertised to patients that they could ask for information in a way that supported them. Staff understood how to apply and meet information standards to support patient's.

The service had information leaflets available in languages spoken by the patients and local community. On request, the service offered patient information leaflets which were translated to the patient's first language. Staff could request translated leaflets through the hospitals contract with a global interpreter and translation service. The service had pregnancy check posters in the waiting areas and clinical rooms translated into different languages.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service had access to interpretation and translation services through the hospital's contract with a global interpreter and translation service. Staff were aware how to access these services.

The service was easily accessible for individuals with limited mobility, for example; there was ramp to the main entrance of the service. Within the service, there was an accessible disabled toilet with a red emergency pull cord which patients could easily reach.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times for treatment were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Managers monitored waiting times for diagnostic images. Waiting times and numbers on the waiting list were discussed at weekly utilisation meetings for the hospital. The average waiting time for an imaging appointment was one week.

The service monitored the number patients who received diagnostic scans within the six week waiting target. All patients were seen within this target between April 2021 and January 2022.

The service monitored the reporting turnaround times. In the last six months, for mammography and ultrasound scans, the longest turnaround time for reporting was three days. For radiography, CT and fluoroscopy scans the longest turnaround time for reporting was four days. For MRI scans the longest turnaround time for reporting was eleven days.

Good

Diagnostic imaging

Managers worked to keep the number of cancelled appointments to a minimum. The service monitored the number of appointments cancelled by the hospital and cancelled by the patient. Managers aimed to minimise the number of cancelled appointments. However, if patient appointments were cancelled, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. However, patient areas did not always display information on how to raise a complaint.

The service did not display information about how to raise a concern in patient areas. The service did not display information on how to raise a concern in patient areas. However, the provider told us that patients attending the hospital for a imaging appointment would come via the outpatients department where complaint information was displayed. The hospital displayed the complaints process on their website for patients to access.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The service had a complaints management policy. Staff demonstrated understanding of the complaints policy and process. Staff received informal verbal complaints and it was their aim to resolve complaints at this stage, without the need for a formal complaint.

The hospital had a three-stage complaints management process. During stage one, the complaint is investigated at site level. If not resolved, stage two involved an investigation centrally by Circle Health Group. If patients were not satisfied with the stage two investigation and complaint response, the final stage was to refer the patient to the independent resolution services. The hospital was subscribed to the Independent Healthcare Sector Complaints Adjudication Service (ISCAS).

Managers investigated complaints. The service had received eight complaints in the last year. Complaints were investigated and the average time taken to respond to complaints was ten days, this was better than their target of 20 days.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers discussed complaints during the monthly imaging team meeting. Learning was highlighted to staff and actions were used to improve the service. The service had a recent complaint where a patient had a scan out of hours and the receptionist on duty was not trained to take payments. This led to the patient overpaying for their scan when they asked Circle Health Group directly for payment details. The service trained additional reception staff to take payments to prevent reoccurrence.

Are Diagnostic imaging well-led?

Good

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

Good

Diagnostic imaging

Leadership

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

The service had leaders who had the skills, knowledge, experience and integrity to run the service. The clinical services manager for imaging had worked for the service for several years and had experience and knowledge to run the service. They was skilled and demonstrated integrity in their approach to running the service.

The clinical services manager for imaging had support from two lead radiographers. Both had worked for the service for a number of years and had experience and knowledge to support the running the service. They were supported to develop their skills and take on more senior tasks associated with their role.

Leaders understood the challenges to quality and sustainability of the service. They were able to identify actions to address them. The service was aware that one challenge was competition from other independent healthcare providers. The service acknowledged that completion of the imaging project would improve patient experience and thereby help with competition.

The service had a clear management structure in place with defined lines of responsibility and accountability. Staff told us they could approach immediate managers and senior managers within the hospital with any concerns or queries. Staff throughout the imaging service told us they felt supported, respected and valued by their managers. Staff told us the executive director came to the department regularly, they were visible and approachable.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.

The Circle Health Group's overarching purpose is "To provide high quality, safe, accessible and affordable healthcare in a sustainable way. Their aim was "To be the most innovative and patient focussed healthcare organisation and, by equipping our outstanding people with leading edge technology, deliver the highest quality care."

The hospital developed their own vision and strategy aligned to the Circle Health Group corporate ones. The hospital's vision and strategy had a clear vision with quality as a top priority.

The hospital has four key principles to help them achieve their purpose. The key principles had quality and sustainability amongst their priorities. Underpinning their principles were eight values for all staff to demonstrate. These include "collaborative and committed" and "agile and brave".

The hospital had strategic objectives based around the patient experience, clinical outcomes, staff engagement and optimal value to promote sustainability.

The hospital used the Circle Health Group corporate tools as a strategy to turn the hospital vision and strategy into action. The tool was named the Circle Operating system (COS). The COS included a "Quality Quartet" as a structure to gather information and measuring progress against the hospitals vision and strategy.

Good

Diagnostic imaging

Staff understood the vision, values and strategy and what their role was in achieving them. Staff demonstrated an understanding of the vision, values and strategy of the hospital. Staff were involved in discussions to shape the vision and strategy for the hospital. The hospital discussed staff contributions to the hospital's principles and values during their daily morning meeting. Staff were awarded with a certificate when they had demonstrated actions which met the hospital's principles and values.

The provider told us that heads of department attended a quarterly strategy day to engage them in the strategy.

Culture

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

Staff said they felt supported, respected and valued. Staff consistently told us they were proud to work for the service and enjoyed their work. The hospital offered awards for staff who went "Above & Beyond" monthly to recognise staff contributions during their work.

There was a strong emphasis on the safety and well-being of staff; for example, the hospital was accredited with a recognised workplace wellbeing award. This demonstrated the hospital's commitment to the health and wellbeing of their staff. Staff were aware of tools they could access to support their wellbeing. The hospital had regular health and safety meetings to discuss health and safety of staff and patients.

There were cooperative, supportive and appreciative relationships among staff. Staff worked in a collaborative and cooperative team to ensure the patient journey within the hospital was smooth. The hospital had introduced a inter-departmental employee experience scheme that allowed all staff to spend a day learning the job of a co-worker. This aimed to improve working relations between staff and help staff gain an understanding of the role and responsibilities of their colleagues.

The service's culture centred on the needs and experience of people who used the service. There were mechanisms to gain patient feedback and improve services as a result such as the complaints and incident investigation process.

The service's culture encouraged openness and honesty at all levels within the organisation, including with people who use services, in response to incidents and complaints. The service complied with the duty of candour requirements.

Leaders understood the importance of staff being able to raise concerns without fear of retribution and operated an 'open door' policy. Staff felt able to raise concerns without fear. Staff could speak up to the hospital's freedom to speak up guardian.

The hospital promoted equality and diversity within the service. The hospital reported on workforce race equality standards focusing on ethnic minority staff proportions in the hospital and access to development opportunities. We looked at their report from March 2020 which showed they had made some improvements in reducing harassment and discrimination of people from a Black, Asian or minority ethnic groups. Leaders acknowledge there is still more to do, and they created an action plan to work towards more engagement and inclusion.

Good

Diagnostic imaging

Governance

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

The service had effective levels of governance and management structures which interacted with each other. The hospital followed the Circle Health Group corporate governance assurance framework which sets out how the hospital organises their governance arrangements from the department in the hospital to board at Circle Health Group. Staff at all levels were clear about their roles and understood what they were accountable for, and to whom.

The hospital had a monthly clinical governance committee which included all clinical heads of departments. The meeting included discussion of learning from incidents, safety alerts, patient feedback and audits. Information for escalation from the clinical governance committee fed into the site management team then up to the Circle Health Group regional team.

The hospital had the following regular committee's: health and safety, medicines management, infection prevention and medical advisory committee. These fed into the clinical governance committee. Meeting minutes from the last year were clear and comprehensive.

The service held yearly radiation protection committee meetings. There was a regular agenda for discussion. For example, radiation protection safety, exposure charts and quality assurance programs. The service said that medical physics were unable to attend the last meeting due to pressures of the Covid-19 pandemic. However, they were available for phone support and there were no actions to follow up.

Managers cascaded relevant information from the clinical governance meeting to their teams through the monthly departmental team meeting.

There was a daily meeting which was attended by a representative from all hospital departments. This meeting focused on; patient numbers, staffing safety, housekeeping capacity, confirmation of safety check completion, fire safety, and staff wellbeing. We saw this meeting on inspection and saw the meeting was carried out effectively. Discussion of this meeting was summarised into a staff daily communication flyer which was emailed to all staff and put on notice boards to update them on what was discussed.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The service had comprehensive assurance systems to monitor safety performance. For example, the service had a systematic program of audits. Where the outcome of safety performance measures was below expected, performance action plans were developed to drive improvement.

The service had robust arrangements for identifying, recording and managing risks. The hospital held regular clinical governance committee meetings where discussion of the hospital's top five risks were a standard agenda item. The imaging department was included in the hospital risk register with an entry about the potential risk to patients and staff crossing the carpark to the mobile MRI and CT units. It mitigated this risk by ensuring staff escorted patients to the mobile scanners. All risks on the risk register had a score and controls to reduce their impact.

Good

Diagnostic imaging

The imaging department had a separate risk register. All risks on the risk register had a score and controls to reduce their impact. For example, the service had a risk around potential slips, trips and falls due to poor lighting at the mobile MRI and CT. The service mitigated this potential risk by putting up temporary lighting. There was an alignment between the recorded risks and what staff said were their concerns.

Information Management

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

The service had a holistic understanding of performance which was presented at the daily morning meeting and during imaging department team meetings. This information brought together people's views of the service with information the service had on care quality, clinical outcomes andfinance. The service used this information to drive improvement.

The hospital regularly sent the results of performance audits to their local clinical commissioning group such as their six week wait data.

The information systems were integrated and secure. The service had robust arrangements to ensure confidentiality of identifiable data, records and data management systems, in line with data security standards. The hospital was audited by an external company to monitor compliance with information security management standards. The hospital had an information security officer and a Caldicott officer.

Authorised staff had access to electronic patient records, which was restricted to individuals by their own login and passwords. All staff completed and were up-to-date with their information governance mandatory training.

The service had effective data or notifications arrangements to ensure they were consistently submitted to external organisations as required such as the Care Quality Commission.

Engagement

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

The service gathered people's views and experiences through patient informal discussions, compliments, patient surveys and complaints. The patient satisfaction survey report showed the service scored 94% for "Overall Impression of Diagnostic Imaging/X-ray".

The hospital created an action plan based on patient feedback to address comments and suggestions from patients and their relatives. For example, it was noted there were limited car parking spaces due to the mobile CT and MRI units taking up a proportion of the carpark. In response, the hospital created more parking spaces for patients.

The service had regular opportunities to meet with staff and engage with them. The service had a monthly half day meeting to bring the team together to review performance data and discuss patient feedback. As part of this half day the team had a specific imaging department meeting. Their purpose was to update teams on operations and share learning. The last three months meeting minutes were clear and comprehensive.

Good

Diagnostic imaging

The hospital executive director formally engaged with staff regularly, through a team brief which they emailed to staff. This outlined key messages for staff such as the hospital's vision and strategy and wellbeing strategies and support.

The hospital also conducted staff surveys. The latest staff survey demonstrated that staff felt they could make a valuable contribution to the success of the organisation and staff felt happy with their balance between work and home life. The hospital displayed the survey results for staff to see and created actions to address concerns raised. For example, they agreed an action to look at ways to become more eco-friendly.

The service demonstrated collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population. The hospital executive director held monthly meetings with the local clinical commissioning groups to discuss waiting time concerns. This helped the service to understand how they could adapt delivery of services to meet those needs. The local clinical commissioning groups were overwhelmingly positive about their engagement and relationship.

During the COVID-19 pandemic, the hospital supported the local NHS trust with diagnostic imaging. The trust was positive about the service's engagement and responsiveness during this time.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation.

The hospital had secured a large amount of funding for an imaging project which was ongoing during our inspection. The funding for this project was used to reconfigure a new department. The service hoped to enhance the diagnostic service and the experience for patients such as improved patient privacy and dignity.

The service set out to strive for continuous learning, improvement and innovation which was encouraged by the leadership team. The service had a robust audit process and part of this process was to identify actions for improvement. The service shared information effectively and used it to make improvements.

The service had effective participation in, and learning from, internal and external reviews, including incidents and complaints. The service learned from a recent incident of a patient fall on return to the ward. The service also noticed there was a theme in complaints about availability of administration staff. As a result the service hired additional administration support.

The service supported development and improvement opportunities for staff. For example, two imaging health care assistants were being supported to become radiographers.

The service participated in the Circle Health Groups "Patient Hour" initiative which describes time dedicated to exploring patient feedback and experience as a team. This initiative focuses on teams thinking about ways to improve the patient experience of the service.

The hospital have introduced "The Green Guardians" who are staff who have an additional role to collaborate with recycling in the local community and the hospital. In the first month, the hospital recycled 86% of the hospital's general waste.

Good

Medical care (Including older people's care)

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

Are Medical care (Including older people's care) safe?

Good

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

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. The provider had a target of 90% for completion of mandatory training. Compliance rates for all mandatory training exceeded this target. Staff who cared for patients undergoing systemic anti-cancer treatment had received training on sepsis management.

The mandatory training was comprehensive and met the needs of patients and staff. The service provided a mixture of online and classroom sessions for mandatory training. Staff received training aligned to the Core Skills Training Framework outlined by Skills for Health.

Staff completed training on recognising and responding to patients with dementia. Staff completed dementia awareness as part of their mandatory training. The hospital had a campaign to train staff to be dementia champions.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us they received an email alert which informed them when their mandatory training was due to be completed.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. The provider had a target of 90% of staff attending safeguarding vulnerable adults training levels one, two and three and children level one and two training. At the time of the inspection, 100% of staff had attended safeguarding training. The safeguarding lead for the hospital was trained to level four in safeguarding vulnerable adults and children.

Good

Medical care (Including older people's care)

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke with, in endoscopy and oncology, clearly identified who could be at risk of abuse and the actions needed if a safeguarding concern was identified. Posters displayed in the staff areas showed the process for recognising and reporting a safeguarding concern.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Corporate and local safeguarding policies were available electronically and reflected current national guidance. The hospital had a named safeguarding lead who was the director of clinical services. Staff could explain how they would respond if they witnessed or suspected abuse. They knew who their safeguarding lead was, how and why to make a referral.

The director of clinical services and the quality and risk manager attended regular regional safeguarding meetings with other Circle Health Group hospitals to discuss safeguarding themes and learning from safeguarding incidents.

Cleanliness, infection control and hygiene

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

The areas for endoscopy and oncology patients were clean and had suitable furnishings which were clean and well-maintained. The clinical areas were compliant with Health Building Note 00-03: Clinical and clinical support spaces. All areas we visited were visibly clean and had furnishings which could be easily cleaned. A patient-led assessment of the care environment (PLACE) audit was last completed in 2019. The department scored higher for cleanliness than the national average of 98.6%. The department score was 99.31%.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Records showed 100% compliance with infection prevention and control measures in the three months before the inspection. The provider had a target of 90% of staff having received infection prevention and control training appropriate to their role. Records showed 100% of staff had received this training. The provider audited infection prevention and control techniques used by staff including handwashing, using correct personal protective equipment and cleaning or decontaminating patient equipment after use. Records showed the areas covered in this report were rated green which meant ‘care is safe and effective’.

Staff followed infection control principles including the use of personal protective equipment (PPE). All staff were bare below the elbows and had access to PPE which included masks, aprons and disposable gloves. Clinical hand washing sinks were available and had laminated posters to remind staff of best practice hand washing techniques. We saw staff decontaminating their hands and equipment before and after patient care. The service managed COVID-19 infection prevention and control measures well. All staff and patients wore fluid resistant disposable face masks and staff actively encouraged and challenged social distancing when it was not being adhered to. Water was tested and reported to the water committee as required by the water safety management regime.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. A clear decontamination pathway for endoscopes was in place. Decontamination processes followed Health Technical Memorandum 01-06: Decontamination of flexible endoscopes. This was audited annually, and the most recent audit showed 100% compliance against this pathway. All equipment test reports were validated by an independent authorising engineer in decontamination. The oncology unit and endoscopy suite used ‘I am clean’ stickers to show that equipment was clean and was ready to use.

Good

Medical care (Including older people's care)

Environment and equipment

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

The design of the environment followed national guidance. Patients attending for an endoscopy were cared for in the inpatient ward or day surgery area, the endoscopy suite and the recovery area. Access to these areas was controlled by an electronic lock with a passcode only known to approved personnel. The oncology unit had a patient waiting room, clinical rooms and a chemotherapy administration suite. The area was awarded a Macmillan Quality Environment Mark in 2019. The award recognises and celebrates environments that meet the standards required by people living with cancer.

Staff carried out daily safety checks of specialist equipment. Records showed daily checks were completed on the emergency equipment in areas used by patients who had an endoscopy or attended for a cancer treatment.

The service had enough suitable equipment to help them to safely care for patients. The provider followed Health Building Note 52 Volume 2 – Accommodation for day care Endoscopy Unit. Records showed and we observed during the inspection there was a robust tracking and tracing system which recorded each stage of the decontamination process for each endoscope, the persons involved, storage and subsequent patient use. All accessory items were marked as single use and used appropriately in accordance with Medicines and Healthcare Products Regulatory Agency guidance (2013). Staff had access to appropriate accessories for any immediate procedure related bleeds.

Staff disposed of clinical waste safely. Clinical and non-clinical waste was separated and stored safely until disposal. All sharps disposal bins we examined for endoscopy and oncology areas were correctly assembled and disposed of safely.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The provider used an endoscopy pathway document for all endoscopy patients. The document included a monitoring section for during and after the procedure which would identify a deteriorating patient. During the inspection, we reviewed five pathway documents and found them completed correctly.

Oncology staff were trained or were receiving training to use the UK Oncology Nursing Society triage tool to assess unwell cancer patients. This nationally recognised tool was used to assess all patients who contacted the oncology team when feeling unwell. Records showed the tool was completed correctly and staff signposted patients to the appropriate service. Patients had access to a trained oncology nurse for assessment and advice at all times. This was via a mobile telephone that was allocated to appropriately trained staff on a rota.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. The endoscopy pathway document had a section for risk assessments which was completed with the patient on admission for their procedure.

Staff knew about and dealt with any specific risk issues. The hospital had an admissions and exclusion policy which identified patients who were medically high risk. The pre-assessment staff assessed the following patient risks: past medical history, previous infection, alcohol intake, smoking and female menstrual history. Any risks were allocated a risk score and rated ‘at risk’, ‘medium’ or ‘high risk’. If a patient deteriorated, the service had a service level agreement to transfer the patient to the local NHS hospital.

Good

Medical care (Including older people's care)

Oncology patients all had a holistic assessment at the start of treatment which assessed patient risk. This assessment was updated at key points during the treatment pathway.

Staff shared key information to keep patients safe when handing over their care to others. As the patient went from the admission ward to the endoscopy area and recovery ward, key medical information was shared with staff. Oncology patients had paper notes which were kept updated by staff. The oncology department had close links with local NHS providers and shared information about patients as needed. All patients had an up to date multidisciplinary care plan in their notes. Patients receiving systemic anti-cancer treatment were given an alert card to show when accessing other health care services.

Staffing

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

The service had enough staff to keep patients safe. The hospital used a staff planning tool to establish the staffing levels needed in relation to patient dependency. Records showed there were enough staff to look after patients attending the hospital for an endoscopy or oncology treatment. Medical consultants worked in the hospital under a practising privilege agreement. Resident medical officers worked at the hospital on a rotational basis. Staff told us that oncology consultants were very responsive and could easily be accessed to provide advice or support.

Managers accurately calculated and reviewed the number of staff needed for each shift in accordance with national guidance. Staffing levels were discussed during the hospital's morning meeting, where the clinical services managers for oncology and endoscopy had to confirm that staffing was safe. The staffing tool was used to plan staffing for five days in advance. The endoscopy staffing requirement was predictable as the department ran the endoscopy list on set times and days. The endoscopy list was run by an endoscopist, an operating department practitioner and a decontamination technician.

The oncology department had a rota with appropriately trained staff allocated to the chemotherapy unit, office and outpatient clinics.

The service had low vacancy, sickness and turnover rates. More information can be found in the main surgery report.

Managers limited their use of bank staff and requested staff familiar with the service. Any gaps in the endoscopy staff were filled by theatre staff who were skilled in endoscopy. The oncology unit had a small number of bank staff who were fully trained to cover any gaps in the rota.

Managers made sure all bank staff had a full induction and understood the service. Bank staff were given a full orientation of the service at the start of their shift. Most of the bank staff had worked at the hospital for several years and were familiar with the service.

Records

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

Good

Medical care (Including older people's care)

Patient notes were comprehensive, and all staff could access them easily. Staff used a patient pathway document for patients having an endoscopy. All the notes needed were in one document and could be easily accessed by staff. The hospital stored the patient notes in a notes trolley when not in use and were planning to implement an electronic patient record.

Oncology notes were stored in the oncology office and were easily accessible to staff who required access.

When patients transferred to a new team, there were no delays in staff accessing their records. The patient pathway document accompanied the patient between departments on the day of the endoscopy. Oncology patients stayed within the one department when having treatment at the hospital.

Records were stored securely. Oncology notes were stored in the oncology office in a lockable cabinet, the key to the cabinet was kept in a locked safe out of hours. The office was locked when not in use and only accessible by key code lock. The code was only known by staff who had the authority to access the office.

The service participated in a hospital-wide audit of patient records. This audit reviewed compliance of records security and completeness. The hospital's compliance from the most recent audit was 96%.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. All staff had received training appropriate to their grade in medicines management, complex medicine calculations and management of controlled drugs. The endoscopy area had medicines for sedation, pain relief and oxygen which is a medical gas. Medicines were prescribed in the patient endoscopy pathway document. A medical gas for pain relief, was administered under a patient group direction. Patient group directions are written instructions that allow health professionals to administer medicines to patients, usually in planned circumstances.

For oncology, systemic anti-cancer treatment medicines were ordered from the supplier for individual patients. The pharmacy prepared and delivered the medicine to the oncology unit as a sealed administration bag marked for the receiving patient. The unit had an electronic prescribing and administering system. The diagnosis, treatment protocol and allergies of each patient were recorded. All patients had signed a consent form for the treatment. We saw staff gained verbal consent prior to the administration of medicine. Two trained nurses were required to administer the medicine. Spill kits were available for staff to use; this enabled staff to safely clear up and dispose of any accidental spillage of the medicines. All medicines had an up to date Control of Substances Hazardous to Health (COSHH) risk assessment. Staff used PPE when handling systemic anti-cancer treatment medicines because the toxicity of these medicines means they can present significant risks to those who handle them.

Staff were aware of compassionate prescribing and gave us an example of a patient who had received a medicine at a reduced cost that ensured they could continue their treatment.

Staff completed medicines records accurately and kept them up to date. Records we reviewed were fully completed and up to date. Medicine compliance was reviewed at the clinical governance meeting. Going forward a medicine's management group was going to be set up and take responsibility for medicines compliance.

Good

Medical care (Including older people's care)

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored securely and at the correct temperature. The clinical room where medicines were stored could only be accessed by authorised staff. Records showed that medicines were prescribed and administered using an electronic prescribing system. One off medicines could be ordered from pharmacy using a paper prescription form.

Staff learned from safety alerts and incidents to improve practice. Medicines safety alerts were shared with the endoscopy and oncology staff promptly and used to improve practice. The service completed a regular medicines management audit. The audit showed good compliance with medicines management in the last six months. Medicines management incidents and learning were discussed during the clinical governance committee meeting. The service had no medicines incidents in the last year.

Incidents

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

All staff knew what incidents to report and how to report them. Staff we spoke with in endoscopy and oncology could describe what incidents to report and the process for reporting incidents. The hospital operated a “Stop the Line” process, whereby any member of staff could stop activity if they encounter a situation that may cause harm. All staff were aware of this process and said they would use it if they saw potentially unsafe clinical practice.

Staff raised concerns and reported incidents and near misses in line with provider policy. Staff reported incidents using a web-based form. They felt confident raising concerns, received feedback and support. The culture was one of learning, not blame.

Managers shared learning with their staff about never events that happened elsewhere. Learning from never events was shared with the teams in the hospital.

Staff reported serious incidents clearly and in line with corporate policy. The provider had an incident management policy which staff could access on the internal intranet. Staff we spoke with could describe the process for reporting a serious incident and reported them in line with the provider’s policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. All staff we spoke with understood duty of candour.

Staff received feedback from investigation of incidents, both internal and external to the service. Feedback and learning from incidents were discussed at meetings in all areas of the hospital. Learning from incidents was shared during a daily safety huddle, a daily staff communication update by email, and during staff meetings, which were minuted. Learning from recent incidents were displayed in the oncology and endoscopy offices for staff to see.

Staff met to discuss the feedback and look at improvements to patient care. Patient feedback was discussed at the daily briefing meetings and improvements to patient care implemented as needed.

Good

Medical care (Including older people's care)

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We reviewed three recent incident reports during the inspection. Incidents were investigated and reported using a template that ensured incidents were investigated thoroughly. The template had a section to document patient and family involvement in the investigation.

Managers debriefed and supported staff after any serious incident. Staff told us that their managers debriefed and supported them following incidents.

Are Medical care (Including older people's care) effective?

Good

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Staff had access to the provider's national electronic database of guidelines and policies. These were monitored and updated as new guidance became available. Policies that needed local guidance were adapted.

The hospital collected and submitted performance data to benchmark themselves against peer services. For example, they monitored clinical outcomes, patient satisfaction, cleanliness and incidents.

The endoscopy suite used the British Society of Gastroenterology guidelines for their procedures. Sepsis screening and management was undertaken effectively in line with national guidance.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Staff made sure patients had enough to eat and drink. Endoscopy patients were not allowed to eat and drink before their procedure, but staff offered them a light snack and drink after the procedure. Post discharge, a nurse called the patients and asked whether they were tolerating food and drink.

Oncology patients were offered a variety of food and drink while they received treatment. The oncology department had stopped treating patients with head and neck cancer as they did not have access to a specialist dietician. The service offered a variety of food that accommodated cultural and religious needs.

Clinical nurse specialists managed symptoms that might affect cancer patients' nutritional intake such as nausea, vomiting, constipation or a sore mouth and used nationally recognised nutritional assessment tools with the patients as needed.

Good

Medical care (Including older people's care)

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The endoscopy patient pathway document included a pain screening section for both during and after the procedure. The endoscopy service had policies, procedures and systems in place to monitor, report and optimise the comfort of patients undergoing a procedure.

Clinical nurse specialists assessed, monitored and dealt with any pain oncology patients experienced using a nationally recognised pain screening tool. The nurses would liaise with the oncologist or GP to provide the patient with pain relieving medicines.

Staff prescribed, administered and recorded pain relief accurately. Records we reviewed showed staff prescribed, recorded and administered pain relief accurately.

Patient outcomes

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

The service participated in relevant national clinical audits. The results of the audits were collated into a quality dashboard and used to improved performance.

Outcomes for patients were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve patients' outcomes. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The endoscopy service monitored and reviewed individual endoscopist performance against key performance indicators and had feedback systems to improve practice. The service participated in the hospital's audit programme which demonstrated compliance and identified areas for improvements to patient care, treatment and outcomes. Results from audits were monitored and discussed at the hospital's clinical governance and medical advisory committees and at corporate level. Any required actions were quickly shared with the department.

The service was accredited by Joint Advisory Group on Gastrointestinal Endoscopy (JAG). The endoscopy suite had achieved JAG accreditation in June 2019 and revalidated in February 2022.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and provided support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers made sure staff received any specialist training for their role. All staff working in the endoscopy suite were qualified to do so. All endoscopy staff had received sedation training which was in line with the British Society of Gastroenterology guidelines. The provider had a policy for granting and maintaining consultant practising privileges. Clinical nurse specialists had completed or were in the process of completing specialist oncology education.

Managers gave all new staff a full induction tailored to their role before they started work. Staff we spoke with told us all new staff had an induction in line with the provider's policy.

Good

Medical care (Including older people's care)

Managers supported staff to develop through yearly, constructive appraisals of their work. Records showed that 100% of endoscopy and oncology staff had received an appraisal in the 12 months before the inspection. Staff told us they also had performance review conversations throughout the year.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. The endoscopy staff attended the theatre staff meetings. Minutes of the meetings were available via email or in the staff rooms for staff who could not attend the meeting. Oncology staff had monthly meetings which were minuted and shared electronically with staff. Copies of the latest team meeting minutes were displayed in oncology office.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Records showed that staff training needs were discussed with managers in regular performance reviews. Line managers aimed to have monthly one to one meetings with staff that reported to them. These meetings were not formally recorded.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff worked closely with providers who referred patients. This helped to provide a seamless treatment pathway. There was effective communication between services, and opportunities to contact other providers for advice, support and clarification.

Patients had their care pathway reviewed by relevant consultants. A consultant was always on call to provide senior medical support.

There was a daily morning huddle at 8.15 am. All staff were encouraged to attend. There was always representation from endoscopy and oncology. The heads of each department met for a daily huddle later in the morning. Managers ensured key messages, operational information, and shared learning were disseminated from the meetings.

All patients' treatment plans were discussed at a multidisciplinary team (MDT) meeting at the local NHS hospital. Membership of the MDT included consultants, clinical nurse specialists, radiologists and histopathologists. The MDT had operational policies and a work programme that described the structure and function of services. The MDT shared the meeting decision for each patient with the oncology unit.

The oncology unit had links with local hospice care providers and referred any patients who had complex palliative care needs.

Seven-day services

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

Consultants were responsible for their own patients and it was a condition of the provider's practising privileges policy that consultants remain available or arrange appropriate alternative named cover if they were unavailable.

Patients of the oncology unit were provided with a telephone number which enabled them to have access to support and advice 24 hours a day and seven days a week. Either a pharmacist or a pharmacy technician provided an on-call service 24 hours a day, seven days a week.

Good

Medical care (Including older people's care)

Health promotion

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

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients admitted for an endoscopic procedure had their alcohol intake assessed and advice was given as needed.

Oncology patients had access to health promotion leaflets provided by a national cancer charity. They also could access support with health improvement from the cancer centre at the local NHS trust.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Dementia and consent training were mandatory for all clinical staff. Training records showed 100% of endoscopy and oncology staff had completed this training.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. All patients were required to give written consent to the endoscopic procedure before the procedure commenced. Consent discussions happened in a private room before the procedure.

Staff made sure patients consented to treatment based on all the information available. Up to date clinical information about the planned procedure, including risks and benefits was provided to patients before seeking their consent.

Staff clearly recorded consent in the patients' records. Staff documented patient consent in the endoscopy admission and pre-procedure checklist.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. A hundred percent of endoscopy and oncology staff had completed Mental Capacity Act and Deprivation of Liberty Safeguards training in the 12 months before inspection.

Are Medical care (Including older people's care) caring?

Good

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Although we were unable to see an endoscopy on the day of the inspection, we

saw many staff interactions with patients. We saw staff of all grades were polite, responsive and caring when dealing with patients. Blinds were closed in the private rooms in the chemotherapy unit while care was being carried out to maintain patient privacy and dignity. A patient-led assessment of the care environment (PLACE) audit was last completed in 2019. The department scored higher for privacy than the national average of 84.9%. The department score was 100%.

Patients said staff treated them well and with kindness. Patients told us they had been treated well and staff often went above and beyond what was expected of them. Many patients had been attending this hospital for a long time and had developed good relationships with the staff.

Staff followed policy to keep patient care and treatment confidential. Staff did not discuss confidential patient information in public areas. Private rooms were available for sensitive discussions between staff and patients.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff interactions with patients were compassionate and understanding. Some staff were trained in mental health first aid and could provide emotional support to those who needed it. Patients could be signposted to counselling services as needed. The hospital ran a patient support group for oncology patients called Chaucer Chatters. The group was paused during the pandemic but was due to restart soon.

Staff demonstrated empathy when having difficult conversations. A private room was available to communicate a serious finding during the endoscopy procedure. The oncology unit had six private rooms and it was possible to have difficult conversations in private.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff described a holistic model of care which enabled them to consider the whole patient and their family when caring for a patient undergoing an endoscopic procedure or receiving cancer treatment. National and local charities provided services such as body confidence and styling workshops, manual for men – facing cancer with confidence, and skin care and grooming workshops.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff checked the patient's understanding of the procedure at all stages of the endoscopy pathway. Private areas were available to discuss the process of assessment, consent and general confidential questions. The oncology unit had up to date patient information on all cancers and treatments.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients and their families were encouraged to provide feedback using an online form on the hospital website. Feedback received was used to improve care and drive improvement.

Staff supported patients to make informed decisions about their care. Patient information leaflets about endoscopic procedures were provided by staff at all stages of the endoscopy pathway.

Good

Medical care (Including older people's care)

Patients gave positive feedback about the service. A patient we spoke with on the day of inspection told us staff were kind, professional and supportive. We saw friendly and caring interactions with patients.

Are Medical care (Including older people's care) responsive?

Good

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

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

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

Managers planned and organised services, so they met the changing needs of the local population. The endoscopy service ran on set days and times throughout the week. Staff told us there was no demand for additional lists during the week or weekend. The oncology unit offered cancer treatments during the week. Out of hours, patients had access to a clinical nurse specialist 24 hours a day and seven days a week. Records showed that patients waited no more than four weeks for their investigation or treatment and often much less.

Facilities and premises were appropriate for the services being delivered. Patients undergoing an endoscopy were admitted to a day unit and had their procedure in a dedicated endoscopy suite. The oncology suite and day unit were clearly signposted and easy to find. The oncology unit had a waiting area with enough seating for the patients. Chilled water was available for patients able to drink.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff told us they had the equipment and skills to care for patients who needed additional support. Any additional needs were identified at the pre-assessment appointment and action taken to arrange additional support. If a patient had needs that could not be accommodated by the hospital they would be signposted to a more appropriate provider.

Meeting people's individual needs

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

The hospital departments had been designed to meet the needs of patients living with dementia. Staff we spoke with told us they had completed dementia awareness training but rarely treated patients living with dementia. Staff were 100% compliant in completing their mandatory training in dementia.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff gave us examples of how they cared for patients with additional needs and used a 'This is me' document. All patients who had additional needs patients were discussed daily at 'comms cell' to ensure staff were aware and supported the care plan. Staff identified if a patient required additional support to meet their needs. Staff recorded this on the service's patient management system. This meant all staff were aware of any additional needs to support their patients.

The service had information leaflets available in languages spoken by the patients and local community. Staff could access information leaflets in different languages should a patient need this. We saw a leaflet clearly displayed in the oncology office giving details of how to book an interpreter.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff we spoke with were aware of how to book an interpreter or signer as needed by patients.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Patients undergoing an endoscopy were given a light snack and hot drink before being discharged home. Oncology patients had a varied menu of food and drink which met the cultural and religious needs of patients.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The hospital had no patients waiting four weeks or longer from referral for their endoscopy procedure. Oncology patients started cancer treatments within four weeks of referral.

Managers and staff worked to make sure patients did not stay longer than they needed to. Patients undergoing an endoscopy procedure, or a systemic anti-cancer treatment were discharged on the same day and did not need to be admitted onto the ward.

Managers worked to keep the number of cancelled treatments to a minimum. Managers coordinated the waiting list for endoscopy. There had been no endoscopy patients cancelled in the 12 months before the inspection. Oncology patients were only cancelled for clinical reasons and rebooked for treatment as soon as was safe to do so.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns. Staff encouraged patients to raise concerns as they occurred. If the concern could not be resolved at the time, patients were informed on how to formally complain. The management team provided real time patient feedback to staff via the daily patient hour during the morning hospital briefing call which covered immediate patient feedback, patient satisfaction survey responses including positives, challenges, actions taken, and lessons learned

The service clearly displayed information about how to raise a concern in patient areas. During the inspection we saw laminated posters informing people how to complain or raise concerns. The hospital held a quarterly patient forum whose membership was available to all.

Staff understood the policy on complaints and knew how to handle them. Staff could describe the complaints policy and the action they would take in the event of a complaint being made by a patient, carer or relative.

Managers investigated complaints and identified themes. The oncology and endoscopy service had received two formal complaints in the 12 months before the inspection. Managers dealt with verbal complaints or concerns from patients as

they occurred. The hospital had a three-stage complaints management process. During stage one, the complaint is investigated at site level. If not resolved, stage two involved an investigation centrally by Circle Health Group. If patients were not satisfied with the stage two investigation and complaint response, the final stage was to refer the patient to the independent resolution services. The hospital was subscribed to the Independent Healthcare Sector Complaints Adjudication Service (ISCAS).

Managers shared feedback from complaints with staff and learning was used to improve the service. Feedback from complaints was shared widely within the hospital and throughout the provider partner hospitals and used to drive improvements to care.

Are Medical care (Including older people's care) well-led?

Good

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

Leadership

Leaders had the skills and abilities to run the service. They supported staff to develop their skills and take on more senior roles.

The hospital had a clear management structure with defined lines of responsibility and accountability. The hospital was led by a senior management team. This included an executive director, a director of clinical services, a quality and risk manager, and an operations manager.

Staff told us managers and the senior management team were visible, approachable and engaged with everyone. They had established a wellbeing hub. This meant staff had immediate access to resources to support their physical, mental and financial wellbeing. Wellbeing was considered at all meetings and was considered business as usual.

Within the endoscopy team, the roles and responsibilities of individuals in the leadership team were well defined and the team was supported by a leadership and organisational structure with clear lines of accountability.

The provider supported leaders by funding leadership courses. For example, one manager had completed an Institute of Leadership and Management (ILM) level three in leadership and told us this gave them the skills to lead their team.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff understood and knew how to apply them and monitor progress.

The Circle Health Group's vision and strategy was 'To provide high quality, safe, accessible and affordable healthcare in a sustainable way'. It was developed by listening to patients and responding to their needs.

The hospital had four key principles to help them achieve their purpose. The key principles had quality and sustainability amongst their priorities. Underpinning their principles were eight values for all staff to demonstrate. These include "collaborative and committed" and "agile and brave".

Good

Medical care (Including older people's care)

The hospital had strategic objectives based around the patient experience, clinical outcomes, staff engagement and optimal value to promote sustainability.

The hospital used the Circle Health Group corporate tools as a strategy to turn the hospital vision and strategy into action. The tool was named the Circle Operating system (COS). The COS included a "Quality Quartet" as a structure to gather information and measuring progress against the hospitals vision and strategy.

Oncology and endoscopy teams contributed to the development of the hospital vision and strategy and told us they were engaged in delivering the objectives of the hospital.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff were consistently positive when they described the culture within the service. They felt supported by all leaders and colleagues. Staff felt respected and valued. They were happy in their role, and stated the service was a good place to work. Staff interacted and engaged with each other in a polite, positive and supportive manner.

All staff we met during our inspection were welcoming, friendly and helpful. We spoke to staff across most grades and various disciplines. They described healthy working relationships, where they felt respected, and able to raise concerns without fear. We were given several examples of how staff had felt able and supported to professionally challenge clinical decisions. This included junior members of staff. The culture was one of learning, not blame. They were encouraged to be open and honest with service users, and staff when things went wrong.

There was good communication in the service from local managers and at corporate level. Staff were kept informed by various means, such as newsletters, team meetings and emails.

The service promoted equality and diversity. It was part of mandatory training and their training compliance was 100%. Managers and staff promoted inclusive and non-discriminatory practices.

A whistleblowing and duty of candour policy supported staff to be open and honest. Staff told us they were able to speak up about concerns and were supported by managers to do this.

There was a focus on staff wellbeing. Staff recognition programmes were established. For example, long service awards, weekly winner of staff recognition award and a recognition wall was shared corporately. Staff could be nominated for 'going above and beyond' at the daily briefing meeting. Staff recognised at the daily briefing were awarded a certificate. Staff received a free lunch once a month (if targets were met) and on their birthday. Staff told us that on valentines' day they were given a chocolate. Staff told us these actions made them feel valued.

The hospital promoted equality and diversity within the service. The hospital reported on workforce race equality standards (WRES) focusing on ethnic minority staff proportions in the hospital and access to development opportunities. The WRES report data from the last year did not indicate any concerns in equality and diversity for ethnic minority staff.

Governance

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

Good

Medical care (Including older people's care)

Staff at all levels were clear about their roles and accountabilities. They had regular opportunities to meet, discuss and learn from the performance of the service. The provider had launched a new governance assurance framework in May 2021. The framework set out how the company governed transparently from ward to board and how this drove the continuous improvement of their clinical, corporate, staff, and financial performance. The framework included terms of reference, and the attendees required for each meeting that fed into the framework. Each meeting had a purpose, and there were clear lines of accountability.

The hospital clinical governance committee met monthly. Meeting minutes included evidence of audit feedback, incidents and complaints, information security, policies, the risk register and business continuity being discussed. Subcommittee reports, such as those from safeguarding, medicines management, and infection prevention and control (IPC), fed into the hospital governance meetings.

There were monthly staff meetings. They were recorded and discussed key topics, such as safeguarding, staffing, quality and risk, IPC, and learning from incidents. Minutes we reviewed confirmed these discussions took place. The endoscopy service had a yearly audit plan.

The medical advisory committee (MAC), oversaw clinical governance issues, the granting and renewing of consultants' practicing privileges, and monitored patient outcomes. The MAC had good representation of different specialities which included diagnostic imaging.

Arrangements were in place to manage and monitor contracts and service level agreements with partners and third-party providers. Contracts were reviewed on a yearly basis, which included a review of quality indicators and feedback, where appropriate.

The oncology team had introduced a proactive check of upcoming appointments to ensure that the multidisciplinary team meeting had taken place and could be evidenced before starting treatment.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The service used a process to help identify and manage risk. This was known as 'Stop the Line.' The process was developed by the car industry. The principle was that if any member of staff identified an issue, they should 'stop the line.' For example, stop a procedure. Stop the line was about resolving an issue as a team, and as it happened, to create and maintain a strong safety culture.

This activated a collective problem-solving process called a 'Swarm.' A swarm was the providers approach to solve a problem or explore an opportunity. A swarm could be called by anyone and enabled the right group of people to come together quickly to discuss an issue. The purpose was to understand an issue fully and agree steps to resolve it.

A risk register was used to identify and manage risks to the service. The risk register included a description of each risk, alongside mitigating actions, and assurances in place. An assessment of the likelihood of the risk materialising, it's possible impact, and the review date were also included. The risk register was reviewed monthly. It was also discussed during communication calls and tabled for review at other meetings. Risks for review or closure were tabled at the relevant committee for agreement of the suggested changes.

Good

Medical care (Including older people's care)

Information Management

The service collected reliable data and analysed it. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service ensured data or notifications were sent to external bodies as and when required. Policies and procedures, and data about performance were stored electronically. Staff were able to access these easily.

The service collected, analysed, managed and used information to support the service, using secure electronic systems. There were effective technology systems to monitor and improve the quality of care. Access to information systems was restricted to only those who needed it, and this kept patient and confidential information secure. The hospital was audited by an external company to monitor compliance with information security management standards. The hospital had an information security officer and a Caldicott officer.

Within the endoscopy service the team had enough technical support to organise and deliver the service efficiently. The information systems were integrated and secure. The service used paper records which were kept in locked clinic rooms or behind the reception desk that was always staffed. Electronic information was kept on computers that were secured with usernames and passwords for each member of staff preventing unauthorised access. Staff logged out of computers when not in use.

Engagement

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

There were systems to engage with staff. The wellbeing of all staff was prioritised by senior leaders.

Leaders collaborated with partner organisations to help improve services for patients. They had a good working relationship with the local acute NHS trust.

Leaders engaged with staff using a variety of methods, including; yearly staff surveys, team meetings, electronic communication, newsletters, staff notice boards and informal discussions. Staff notice boards included information about human resource matters, how they could obtain vouchers for eye tests, wellbeing support, training opportunities, COVID-19 updates and how the service had incorporated staff feedback. Staff felt their views and opinions were listened to, and they felt valued.

Team meetings were monthly and provided dedicated time for the department to share information and review performance. For example, staff who had attended clinical learning events shared the learning with the wider team. The agenda was designed by the team to meet their needs. The team were asked what they wanted to focus on. Meetings reviewed learning about how other teams work to better understand the overall patient pathway.

The service engaged with patients and sought feedback to improve the quality of the services provided. Patient feedback forms provided areas of open text for qualitative information. Patient feedback was displayed and shared with the team and used to improve the service.

The service worked with local NHS trusts to meet the needs of the local population. They asked all patients to complete a provider feedback questionnaire about their experience. They were also encouraged to complete reviews on search engine websites.

Good

Medical care (Including older people's care)

The results were collated on a monthly basis and patient response rates and rating within categories were ranked against all Circle Group hospitals. Results were reviewed at the clinical governance and MAC meetings. Patient satisfaction was also discussed at the head of departmental meetings. The service created an action plan to address trends from feedback.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

Oncology staff had access to a range of learning opportunities. A national cancer charity and an NHS oncology specialist hospital offered a ranged of face to face courses and online learning. Staff attending the training sessions shared the learning with the wider team to improve all staff knowledge.

Staff told us that innovation to improve their service was encouraged by the team. For example, the oncology team were developing haematology competencies for staff which in turn would improve the care given to patients with a haematology cancer.

The hospital had introduced “The Green Guardians” who were staff who had an additional role to ensure the hospital collaborated with recycling schemes in the local community. In the first month, the hospital recycled 86% of the hospital’s general waste.