Circle Health Group Limited

The Duchy 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 location improved. 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 most patient risks, 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. Staff gave patients pain relief. 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.
- 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:

Surgery:

- The theatre doors did not stay open: staff said a quote to replace the doors had been obtained; in the interim this was identified as a risk on the risk register.
- The resident medical officer did not attend all meetings which were relevant to them.
- Oxygen prescribing was inconsistent in that the dose and frequency of oxygen administration was not documented clearly in one patient's prescription chart.
- Environmental temperature monitoring in the ward dirty utility area had not been reported when the agreed temperature was exceeded.
- We observed staff interaction with two patients and observed on both occasions the patients were not asked to confirm their pain scores.

Outpatients:

- Although items of equipment we checked were in date for service, labels indicating service dates were obscured on some items. We noted monthly reports are run to assure all hospital equipment is in date.
- Although patient records were complete some were not in chronological order or integrated into the care records.

Diagnostic imaging:

Summary of findings

- Although not part of the inspection we visited the reception desk in the reception area under construction. We subsequently spoke with the registered manager to ensure the reception desk area was wheelchair accessible, reflecting the requirements of patients with a physical disability. The hospital immediately reflected our comments in the project construction. Following the inspection, the provider confirmed the following. We have reviewed the wheelchair accessibility at the imaging reception desk to ensure wheelchair accessibility and we are assured that access is available at main reception desk.
- Although items of equipment we checked were in date for service, labels indicating service dates were obscured on some items. We noted monthly reports are run to assure all hospital equipment is in date.
- For the visiting mobile magnetic resonance imaging vehicle, we were assured that when this service is on site it falls under the hospital's policy and governance processes. However, on inspection we did not find these processes were documented.

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 improved. We rated it as good because: See the summary above for details. We rated this service as good because it was safe, effective, caring and responsive and well led.
Outpatients	Good 	See the summary above for details. We rated this service as good overall; good ratings for being safe, caring, responsive and well-led. Effective was inspected but not rated.
Diagnostic and screening services	Good 	See the summary above for details. We rated this service as good overall; good ratings for being safe, caring, responsive and well-led. Effective was inspected but not rated.

Summary of findings

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Summary of this inspection

Background to The Duchy Hospital

BMI Healthcare joined the Circle Health Group in January 2020. The Duchy Hospital was benefitting from a major £250m national investment programme in facilities, technology, and people.

The hospital primarily serves the local communities in and around Harrogate but will accept patient referrals from outside this geographical area.

The Duchy Hospital has a new registered manager who was registered through the Care Quality Commission on the 5 October 2023.

The hospital provides a range of surgical, outpatient and diagnostic imaging services to the NHS and other funded (insured and self-pay) patients and collaborates predominately with consultants from local NHS hospitals. Surgical services at the Duchy Hospital provide day and overnight facilities for adults only undergoing a variety of procedures.

The hospital has access to the latest technology and equipment including:

Two theatres with laminar flow and a minor procedures suite

Diagnostic Imaging X-Ray and Ultrasound

27 private rooms with ensuites

10 Consulting Rooms

Holistic and Wellbeing Programme - Yoga and Pilates

Physiotherapy Suite

Health Screening

The hospital was inspected on 31 July 2017 for safe and well led. A requires improvement rating was awarded following this inspection.

We rated well-led as requires improvement because:

- Although there were many improvements in governance, leadership, staff and public engagement and staff morale/ culture many of the new processes and initiatives were still in their infancy. The hospital leaders knew they had more to do to ensure they were embedded, and improvement sustained.
- Improvements had been made in the hospitals approach to the Workforce Race Equality Standard (WRES) but the hospital leaders acknowledged they were not yet fully compliant with the requirements.

At this inspection we observed ongoing improvements had taken place and were sustained. Governance, performance, and risk processes were now embedded and evidence of this was seen through the performance dashboard, audit and monitoring processes employed and feedback from staff and patients. The service was now fully compliant against the Workforce Race Equality Standard.

Summary of this inspection

This inspection was unannounced.

The hospital is registered to provide the following regulated activities:

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

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 surgical service.

How we carried out this inspection

During the inspection visit, the inspection team:

- Visited one location, looked at the quality of the overall environment and observed how staff were caring for patients.
- Spoke with the Registered Manager, members of the senior management team, staff and consultant staff.
- Reviewed 53 patient care records and treatment records.
- Observed nine patient surgical pathway sessions from admission to discharge.
- Attended 5 theatre briefings.
- Spoke with 20 patients and one relative.
- Looked at a range of policies, procedures and other documents which related to the running of the service.

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.

Areas for improvement

Action the service SHOULD take to improve:

Surgery

- The provider should consider allowing the resident medical officer the opportunity to attend meetings to allow them the opportunity to be involved in clinical governance issues and learn from decision making at the Medical Advisory Committee.
- The provider should ensure that oxygen prescribing follows medicines management guidance. (Regulation 12)
- The provider should ensure that all waste containers are secure when unattended. (Regulation 15)
- The provider should ensure that where environmental temperature monitoring is in place when the temperature exceeds the agreed temperature it is reported and checked. (Regulation 15)
- The provider should encourage staff to report staffing incidents. (Regulation 18)

Outpatients

- The provider should consider the labels which identify the service dates on equipment are not obscured.
- The provider should consider that patient records be arranged in chronological order or integrated into the care records.

Summary of this inspection

Diagnostic Imaging:

- The provider should consider the labels which identify the service dates on equipment are not obscured.
- The provider should ensure that identified assurance processes linked to the hospital's governance arrangements are in place for the visiting mobile magnetic resonance imaging vehicle. (Regulation 17 (2) (f))

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 and screening services	Good	Inspected but not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Surgery

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

Is the service safe?

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 mandatory training matrix identified the training which each staff group was expected to complete.

The training lead monitored mandatory training compliance and informed clinical service managers should staff groups have training which was about to expire or needed to be completed. An alert system informed staff to the upcoming expiry of each mandatory training subject at three- and six-month intervals.

Staff signed up to training courses through 'learning space' and following attendance this was documented on the learning space system.

Mandatory training statistics for all staff groups confirmed compliance ranged from 83.7% to 100% throughout 2022 to 2023. Two subjects fell below 90%: adult immediate life support (83.7%) and Fire Safety (89.9%).

Sepsis training statistics for nursing and administration staff groups confirmed compliance as 100% throughout 2022-23.

All staff had completed the Oliver McGowan mandatory training on learning disability and autism and also dementia awareness 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 governance arrangements were in place.

Good

Surgery

The director of clinical services was the safeguarding lead at the hospital and was to be trained in adult safeguarding at level 4 alongside the registered manager. A Circle healthcare limited corporate safeguarding lead was contactable.

All staff received training specific for their role on how to recognise and report abuse. Staff completed level two and level three safeguarding training; overall training compliance was 97.8%. Training statistics also confirmed that 97.8% of staff had completed level two safeguarding children's training.

Staff had received additional training to ensure that they could identify and support people with additional needs and for those people at risk of suicide and self-harm. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. At the preadmission assessment staff asked questions about the support the patient required postoperatively and as part of the discharge process.

Safeguarding guidance was in place to advise staff. Staff knew how to identify adults at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Due to the low number of safeguarding referrals and incidents, safeguarding supervision took place immediately after a safeguarding referral was made. These were discussed on an individual basis, so all practitioners involved were supported.

Safeguarding incidents were reported through the incident reporting system which ensured the Circle Healthcare Limited corporate team were informed of these events. Should a safeguarding event be identified the local authority referral form was completed electronically.

Hospital safeguarding representation was present at the biannual North Yorkshire private providers safeguarding meeting, the last meeting took place two weeks prior to the inspection.

Quarterly safeguarding committee meetings took place at The Duchy Hospital and safeguarding issues, which included referrals and incidents were discussed. In addition, safeguarding incidents were discussed at team meetings and the daily activity meeting as they arose. Staff debriefing sessions took place after safeguarding events.

Meetings took place with the local NHS Trust and other independent providers where issues were shared.

Safety was promoted in recruitment practice and through ongoing monitoring. Enhanced disclosure and barring checks and reference checks were conducted on all staff before they commenced work at the service. In addition, medical staff completed biannual reviews with the registered manager and additional checks included yearly indemnity checks.

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 designated infection, prevention, and control (IPC) lead was supported by departmental IPC link staff.

Good

Surgery

Infection prevention control (IPC) link nurse roles were present within the service. Clinical areas IPC link nurses accessed additional training. Meeting minutes from the IPC leads September 2023 meeting reminded staff of the importance of the bare below the elbow practice even when staff were non-clinical.

Staff followed infection control principles including the use of personal protective equipment (PPE). Hand rub was located throughout the hospital. National Patient Safety Agency five moments to hand hygiene and hand cleaning techniques were displayed.

Guidance on respiratory issues such as Covid 19 was in place for staff and patients.

Ward areas were mostly visibly clean and had suitable furnishings which were clean and well-maintained. We noted some dust in the grills in the ward visitor's toilet and in rooms 19 and 24 and also some dust on the top of the shower rail in room 19. We escalated this to staff and these areas were cleaned immediately. Throughout the visit we returned to these areas and noted them to now be visibly clean.

Some pictures were displayed in a corridor leading to the main ward area which staff members had produced did not have a wipeable covering. This was escalated to a staff member to ask the infection, prevention, and control lead for advise on this.

An internal domestic service was provided by four full time housekeepers over seven days. An external cleaning company deep cleaned areas six-monthly, and records showed deep cleaning took place. The quality of cleaning was monitored by the operations manager, the Director of Clinical Services and the infection and prevention lead nurse.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Cleaning checklists on the ward and in theatre confirmed all tasks were completed daily. The service performed well for cleanliness. Hand hygiene, cleaning and environmental audits confirmed a consistent 100% compliance from April 2023 until October 2023 across all areas within the hospital.

The October to December 2022 peripheral cannula and urinary catheter care bundle audit confirmed 100% compliance. Ongoing auditing had taken place for peripheral cannula care bundles throughout 2023; all confirmed 100% compliance.

Sterile supplies were supplied from another hospital which offered a 24-hour turnaround time. Certification confirmed compliance against the quality management system for medical devices.

Flushing of taps helped control legionella in hot and cold-water systems. The 6 November 2023 maintenance report confirmed legionella was not present in all areas.

Staff worked effectively to prevent, identify, and treat surgical site infections. New admissions to the service were screened through the IPC patient infection risk assessment tool. Over the last 12 months there had been no cases of Methicillin Resistant Staphylococcus Aureus or Clostridium Difficille infections. Some superficial surgical site infections per 100 bed days were reported for eight months from November 2022 until October 2023. The surgical site infection range was from 0.806 to 4.040 per 100 bed days.

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.

Good

Surgery

The design of the environment had facilities which met the needs of patients and their families. The local clinical environment was well maintained. Patients could reach call bells and staff responded quickly when called.

The surgical areas within the hospital included two theatres with laminar flow and inpatients stayed in one of the 27 private bedrooms with ensuites located in the main ward area. Currently, 20 bedrooms and ensuites were in use.

We observed works in the diagnostic imaging department and main reception area. The diagnostic imaging department had been relocated temporarily.

In room 19 we observed the window blind could potentially be a choking hazard as it did not have a clip on the side which fastened it to the wall. This was escalated to the registered manager following the inspection who confirmed they would ensure this risk was removed.

The theatre doors did not stay open: staff said a quote to replace the doors had been obtained; in the interim this was identified as a risk on the risk register.

The service had enough suitable equipment to help them to safely care for patients. We undertook random checks of equipment and saw that the majority had dates identified. A thermometer and defibrillator on the ward did not have these maintenance stickers which confirmed when the date of the next maintenance check was due. We raised this with staff who told us that all equipment had checks completed. Many of the theatre equipment service labels were smudged.

Maintenance records confirmed that equipment had either been maintenance checked, calibrated, or serviced.

Management of safety alerts and national guidance advised staff of the process to follow and accountabilities in this area. Recording systems allowed details of specific implants and equipment to be provided to the health care products regulator. Healthcare products regulatory agency alerts were shared through the governance reporting system. Urgent alerts were sent out as a 'Flash Alert'.

Staff conducted daily safety checks of specialist equipment. The resuscitation trolley daily checklists for February, June and October 2023 confirmed the majority of daily checks had been completed in the theatre and ward areas. In addition, monthly resuscitation equipment checks were documented. We checked random pieces of resuscitation equipment and some resuscitation medicines all of which were in date.

Anaesthetic equipment daily checks were documented, signed, and dated as per Association of Anaesthetists of Great Britain and Ireland guidance.

Theatre ventilation systems verification reports issued November 2023 confirmed the equipment in theatre two had passed the checks. One recommendation was identified for theatre one and for the theatre recovery for which the work was scheduled to take place in February 2024.

Sink surrounds on clinical areas were not a sealed unit due to the access requirements for pipes. However, we observed that these units were wipeable and clean.

Staff disposed of clinical waste safely. Storage of clinical waste containers were in a locked and contained area.

However, we observed that one unlocked general waste storage container was located at the back of the hospital. This was escalated to staff throughout the inspection. We rechecked these storage containers and found the general waste bin remained unlocked.

Arrangements for the control of substances hazardous to health (COSHH) were in place. However, on the ward the door to the room this was kept in was unlocked and the cupboard these substances were kept in was also unlocked. Staff confirmed this was normal practice. We escalated this practice to managers and throughout the inspection went back to this area and found both doors locked.

Temperature monitoring was in place in the dirty utility room on the ward due to the storage of COSHH products. We saw that temperatures should be below 25 degrees. We checked the monitoring book and observed that the temperature had been slightly above 25 degrees for six days. We asked what the escalation process was and staff said the maintenance team would be contacted; however, this had not been done in this instance.

COSHH products were also stored in a non-patient area. We observed one container on the floor which could constitute a trip risk. Other non- COSHH products were stored in this room. We escalated this to managers who checked the COSHH products were stored at the correct temperature; and the room was tided so the non- COSHH products were raised off the floor.

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 level agreement with the local NHS Trust ensured the transfer of patients should they deteriorate.

Deteriorating patient guidance, tools, flow charts and specific condition guidance was available, for example, sepsis guidance and major haemorrhage flow charts.

Twenty-eight staff had received training in the care and communication of the deteriorating patient (CCDP); eight staff had completed advanced life support training.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The service used the national early warning score (NEWS2) tool for the clinical assessment of patients. Seven patients' records confirmed they had NEWS completed, scored, and evaluated.

Continuous monitoring on the compliance of NEWS2 escalation and documentation had taken place. NEWS2 audits from November 2022 to October 2023 confirmed 100% compliance in their use. Audit results were discussed in unit meetings and escalations fed into the hospital clinical governance committee. When necessary, these were discussed at the corporate clinical governance committee.

The service used the American Society of Anaesthesiologists (ASA) physical status classification system as a grading system to determine the health of a person before a surgical procedure that required anaesthesia.

The blood fridge was managed by the outpatient's department and local NHS Trust.

In theatre recovery staffing levels were one nurse to one patient.

Good

Surgery

Staff handovers

Staff shared key information at shift changes and handovers to keep patients safe when handing over their care to others. Safety huddles took place twice daily on the ward area with the resident medical officer and nursing staff present. At these meetings checks were made around staff resuscitation training status and staff were then assigned roles for the day.

An activity meeting with the whole of the multi-disciplinary team took place at 9.30am to share activity and other information, for example, patient concerns and safe staffing.

Theatre team briefings took place prior to the theatre lists commencing. However, we observed that two patients on the list had the same first name, and this was not highlighted on the list. Following the inspection, the provider confirmed that the safety briefing highlighted patients with the same surname and not their first names.

Risk assessments:

Patients whose needs could be met through normal ward care were identified through the hospital risk assessment process to ensure only those patients would be admitted. Patients who required a higher level of care were referred back to the NHS or their GP.

Staff completed risk assessments and psychosocial assessments for each patient at their pre-admission call and / or visit. This information was available and was shared with the multi-disciplinary team prior to the patient's admission if they had any specific needs to consider prior and post treatment.

Eighteen patients records confirmed risk assessments such as venous thromboembolism (VTE), pressure area, falls and moving and handling assessments were carried out for some patients dependent on need. For example, 12 patients' records confirmed VTE assessments were completed on admission and VTE status reassessed daily with the exception of one final VTE score.

Preoperative risk assessment audits compliance levels were 100% from September 2022 to September 2023.

Falls and venous thromboembolism risk assessment audits compliance levels were 100% from August 2022 to July 2023.

Five patients' records showed evidence of discharge planning from pre - admission to the service.

The service had 24-hour access to mental health liaison and specialist mental health support.

Safety Audits:

Local Safety Standard for Invasive Procedures (LocSSIP) guidance was in place.

During surgical procedures we observed that surgical safety checklist practice was embedded. We observed and reviewed five surgical safety checklist checks in patients notes and saw all the necessary checks were completed as per guidance.

We also tracked four patients through theatre and observed all surgical safety checks completed.

Good

Surgery

Monthly surgical safety checklists monitoring confirmed compliance as 100% over the last 12 months. The audits included: major surgeries, minor operations, cataract, and endoscopy.

The outcomes from these audits were discussed at team's briefs and team meetings and were a standard agenda item on the departmental minutes. If issues were raised these were escalated to the director of clinical services and the senior management team. In the event of immediate concerns staff were encouraged to 'STOP THE LINE' which is when the activity stops, and senior managers informed. This allowed issues to be resolved at source and created an opportunity for collective problem-solving, which was known as a swarm. This allowed learning to take place and joint decision making for actions going forward.

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.

Paper records were generally stored securely. On the ward area we observed that one records storage cabinet was unlocked and out of sight of the staff. We escalated this immediately and staff locked the cabinet which was rechecked throughout the inspection and found to be secure.

Patients' records were managed by the medical records team. Patient records were scanned on to the medical records tracking system; each record had a unique number and scanned barcode attached to the front cover. When medical records were required for clinics, they were tracked to that department.

Patient files were sent off site for scanning onto the medical records system after six-months post patient discharge, but where available to print off again if required.

When patients transferred to a new team, there were no delays in staff accessing their records. Patients' records were always onsite whilst the patient was undergoing treatment.

Patient notes were comprehensive, and all staff could access them easily. We reviewed 18 patients' records; saw the majority of risk assessments were completed along the patient's pathway which also included other information, for example, evidence of discharge planning from admission and evidence of the patients' voice and involvement.

Theatre registers were fully completed by staff.

We saw effective systems in place to manage and monitor patients' records. Quarterly patient records and discharge audits took place to ensure they were up to date and findings were reported back to departments. The patients' records audits for April to July 2023 confirmed 100% compliance and confirmed no gaps in current practice. The results of these audits are also discussed at the Clinical Governance Committee, Leadership Meetings, and the Medical Advisory Committee.

These reviews identified improvements were required in that the documentation should be in the correct order and loose documentation in the patient files. The hospital agreed an action plan which included the introduction of weekly audits. A reaudit was planned for December 2023 to identify progress made in these areas.

Good

Surgery

Nurse staffing

The service had 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.

Managers calculated and reviewed the number and grade of nurses and healthcare assistants (HCA) needed for each shift. The clinical service manager (CSM) used the Circle Power BI tool to plan safe staffing levels and skill mix based around Circle Health Groups safe staffing framework. The weekly extended activity meeting identified future patient bookings up to six weeks in advance and for those patients who agreed to surgery closer to their theatre date so that the service was alerted to an increase in patient cases and their complexity. Activity was also discussed at the daily morning communication meeting.

The monthly staff utilisation figures were grey, amber, green rated. The green rating was between 80% to 100% and confirmed safe staffing levels that month. From 1 October 2022 to 1 October 2023 eight ratings were identified as green, therefore, staff staffing levels were achieved. On one occasion in August 2023 a grey rating was identified due to annual leave and unexpected sickness. To mitigate this the CSM worked clinically in the nursing numbers to maintain safe staffing levels.

Skill mix was planned by prospective theatre activity reviews one month in advance on a rolling basis. The number of major and minor cases, general and local anaesthetic cases were considered, and staff rosters and skill mix planned accordingly.

The planned staffing for 20 beds was two trained staff and one healthcare assistant during the day and two registered nurses at night. Staff said there was no flexing of the staffing rota dependent on patient acuity and the number of patients planned to attend for the day; staffing at night could consist of one trained nurse supported by one agency trained nurse to care for two to four patients on the ward.

The service had 3 whole time equivalent nurse vacancies, which were difficult to fill.

The CSM was supernumerary and not included in the shift numbers. However, supported the ward and patients if required.

Two ward sisters worked clinically; one was returning to work through ‘keep in touch’ days. The remaining sister had a half day allocated weekly to undertake management duties.

Two senior staff nurses were employed one was full-time, the other nurse worked 22.5 hours per week, both nurses were included on the nurse on call rota.

If the ward was busy a twilight nurse or health care assistant was employed, or available staff were redeployed from another area from within the hospital to help out. However, staff said this did not always happen. Theatre staff collected patients and took them to theatre which meant staff did not leave the ward area.

Staff said the ward team were brilliant and supported each other, but on occasion staff said they had not been able to take breaks. We asked how many staffing incidents had been reported and were told there were none. We discussed this with senior staff who said that if there were shortfalls which meant staff could not take their breaks another trained nurse would be redeployed from another area within the hospital. If unable to action this either the resident medical officer or clinical nurse manager would stay on the ward so staff could take breaks.

On call arrangements ensured staff could contact an on call clinical nurse or manager.

When additional theatre lists took place at the weekend staff said additional staff were employed to cover these theatre lists in theatre and on the ward so that patient care remained safe.

The wards turnover rates had fluctuated across the 12-month period, with a rate of 38.1% in October 2023, which equated to four whole time equivalent staff.

The wards rolling 12-month average for sickness rates was 1.9% which related to between one to four staff off sick per month.

Theatre Staffing

Theatre staffing levels complied with the Association of perioperative practice (AfPP) standards. There was ongoing recruitment in theatre services to increase the service to a six-day service. Staff said they used two regular bank and agency staff who were both on long term contracts.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Staff confirmed bank and agency staff were employed and prior to employment their competencies and skills were checked by their agency provider. The August and October 2023 staffing rotas confirmed the weekly use of agency staff ranged from a minimum of one to seven shifts, for example, week commencing 31 July to 6 August 2023 agency staff worked three-night shifts and two early shifts.

Theatres turnover rates ranged from 9.6% (January 2023) which increased to 21.1% from August 2023 to September 2023 at 27.1%. In total this related to five whole time equivalent staff .

Theatres rolling 12-month average for sickness rates was 3.10%. Over this period staff monthly sickness levels ranged from five to eight staff monthly.

Bank and / or agency nursing staff were employed on the ward and in theatres over the last 12-months. Monthly ward bank and agency staff was from 72 hours (February 2023) to 305.75 hours (March 2023). Agency and bank hours employed on the ward throughout the remaining months ranged from 127.5 to 298.5 hours.

Bank and agency staff employed in theatre monthly was from 4.5 hours (January 2023) to 146.7 hours (June 2023). For the remaining months agency and bank hours was between 26.75 to 135.2 hours.

Medical staffing

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

The service had enough medical staff to keep patients safe and a designated Medical Advisory Committee (MAC) Chairman was identified for the service.

An anaesthetic consultant lead was identified for the service and staff said that the anaesthetist present at the patient's surgery was available to review patients post-operatively when required.

Good

Surgery

There was good attendance by anaesthetist at medical advisory committee meetings; anaesthetists were also invited to join committees, for example, resuscitation and governance.

Consultants were employed through practising privileges agreements. We reviewed six consultants' personnel files and saw all relevant checks were made. MAC discussions and offer letters were confirmed prior to them being employed through the hospital.

Staff told us that consultants were expected to live within an hour of the hospital and individual patients remained the responsibility of their named consultant.

Where concerns were raised about consultants, a robust process was in place to investigate these concerns.

Consultant microbiologist support was provided through the local NHS Trust.

Two resident medical officers (RMO) were employed through an agency by the service, each RMO worked a week on and then had a week off work. The resident medical officer was available 24/7.

Prior to working at the service both RMOs were inducted into the hospital. Staff said consultant staff supported the resident medical officers. However, conversations identified that RMO staff did not attend meetings for example governance meetings, the medical advisory committee which would allow them to be informed of lessons learnt, risks and alerts to the service.

Medicines

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

Medicines management and local microbiology protocols for the administration of antibiotics were in place. The local microbiology protocols were adopted from the local NHS Trust.

Staff generally followed systems and processes to prescribe and administer medicines safely, however, oxygen prescribing was inconsistent in that the dose and frequency of oxygen administration were not documented clearly in one patient's prescription chart. Staff told us that this practice had not been audited and going forward audits would take place with a view to improve practice. We also observed the resuscitation sharps box on the ward resuscitation trolley was not dated or signed.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Medicines reconciliation of patients' medicines took place within 24 hours of admission to the service.

Patients' allergy status was checked at pre-assessment and documented on their medicines chart.

Staff reviewed patients' medicines regularly and advised patients and carers about their medicines. Discharge medicines were prepared in advance of the patients discharge.

Staff completed medicines records accurately and kept them up to date. We reviewed nine prescription charts which were complete.

Controlled drugs (CD) were monitored through daily and twice daily checks and were documented.

Good

Surgery

Quarterly controlled and medicines management audits compliance levels for the ward and theatre was 100%. Themes and trends from audits fed into the medicines management governance meetings attended by a staff member from each department.

The pharmacist told us that any near misses which happened in pharmacy were recorded in a book and not in the incident system. We escalated this to senior management who advised that going forward all near misses would be recorded as an incident. Following the inspection, the provider confirmed it was recognised practice in the pharmacy industry that near misses (good catch's) were recorded on a near miss log and not in a reporting system. Near misses' trends would be discussed at the medicines management meeting. The senior management team said they would ensure this practice took place.

No patient group directions were in use at the hospital.

To ensure effective patient outcomes the medicines service measured their performance against another Circle Healthcare hospital in Yorkshire.

Staff learned from safety alerts and incidents to improve practice.

Prior to discharge patients received guidance about their medicines. This guidance included the management of side effects, how to take medicines to manage their pain, how to reduce the dose of pain medicines such as codeine and how to contact the ward and/or Pharmacy for advice if required post-discharge. An individualised medicines information leaflet was supplied with the medicines the patients were prescribed to take home.

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 raised concerns, reported incidents, serious incidents and near misses in line with provider policy. Staff understood the duty of candour and had completed training in this area. Staff described the importance of being open and transparent and the importance of patients and families being given a full explanation if and when things went wrong. There had been no duty of candour incidents in surgery over the last 12 months.

Managers investigated incidents thoroughly and patients and their families participated in these investigations. Staff met to discuss the feedback and look at improvements to patient care. Managers debriefed and supported staff after any incidents. Staff said feedback was shared locally and at team meetings. We reviewed one incident, and the learning identified a need for a 4pm resuscitation huddle in the hospital which we observed take place during the inspection.

Incidents discussed at monthly clinical governance meetings informed leadership teams of activity in this area. The September 2023 clinical governance summary report provided an overview of statistical data, which included falls, complaints, and incidents. The incidents data identified the incident, actions, and level of harm for each incident. We observed that the majority of incidents were classified as no harm.

Good

Surgery

Surgical mortality and morbidity reviews had fed into service improvement and evidence was seen that changes had been made as a result of feedback. We saw the information pertaining to one review. The structured judgement review identified examples of exemplary care and areas of learning. For the areas of learning documentation audit monitoring was to be implemented and spot checks carried out to confirm admission documentation was completed.

Is the service effective?

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.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The surgical pathways were based on principles of best practice from the Royal Colleges and the National Institute for Health and Care Excellence. We saw evidence that current surgical policies and pathways were referenced from the above-mentioned professional bodies. Policies reviewed by the team were seen to be in-date and follow national guidance.

Evidence based clinical pathways and guidelines were followed to reflect professional guidance. In addition, internal reviews observed clinical practice. Surgical safety guardians were on the floor daily to support adherence to policy. Standards were measured through audits whose outcomes were reported at local governance meetings.

Staff confirmed local operating procedures reflected professional guidance through the utilisation of corporate policies and a robust admission criteria. Surgical patients were discussed, and pre-operative assessment data were analysed by the multi-disciplinary team the week before admission. This ensured the right staff, with the correct skills and all the required equipment was available.

Duchy Hospital achieved the Association of Perioperative Practice accreditation programme in December 2022.

Guidance was in place for the recording and management of medical devices. The hospital recorded surgical implant information on mandated registries and records of all implanted prosthesis were kept locally. This practice was monitored locally for compliance and by random observational audits and reviews from both Area Director of Clinical Performance and/or corporate site visits.

The Duchy Hospital sub-committee on audits and risk discussed issues and improvements bi-monthly. At the monthly audit working group quality and risk managers from every hospital shared learning and requested support on any audit challenges or issues encountered. The hospital had identified monthly, quarterly, and annual clinical audits which were linked to standards or guidance.

Clinical audits were benchmarked against other Circle Healthcare Group hospitals. The five surgical audits seen confirmed the Duchy Hospital scored higher than other hospitals in the group. Scores ranged from 97.30% to 100%. The Circle Healthcare Group all hospitals scoring ranged from 95.27% to 97.03%.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers.

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.

Staff said over the last 18 months catering services had improved at the hospital. Communication had improved between the catering and nursing teams and hostesses now visited the wards and ensured patients menu choices and preferences were identified.

Patients' food preferences chosen from menus were collected by the hostess staff daily. Staff said that should patients request foods which were not on the menu they would try to accommodate the patients request.

We reviewed a menu card and saw a wide selection of food choices provided, for example, vegan, vegetarian, meat based.

Food was available in the ward kitchen for patients who were hungry outside of the main mealtimes. Patients could access hot meals until 8pm.

Information about patients' allergies was shared with the catering department following the patients preassessment visit or call to ensure that foods provided did not contain any substances which could provoke an allergic response.

Patients waiting to have surgery were not left nil by mouth for long periods. Patients received clear instructions at their pre-assessment visit in relation to their last meal and drink prior to their investigation or surgery.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition of which we saw from 10 patients' records these tools were completed.

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.

The service did not have a pain specialist nurse practitioner; however, patients pain needs were assessed at pre-admission and again on admission and throughout their stay. The pharmacist and resident medical officer undertook these reviews to ensure patients received adequate pain relief.

We observed staff interaction with two patients and observed on both occasions the patients were not asked to confirm their pain scores. On one occasion the patient was asked 'You're not in any pain are you?'

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Four of five patient records confirmed ongoing assessment of their pain and ongoing review had taken place.

Staff prescribed, administered, and recorded pain relief.

Patients confirmed they had received pain relief soon after requesting it.

Quarterly pain management audits took place; compliance ranged from 95% to 100%. The audit which scored 95% compliance was from April to July 2023 and identified one action which related to documentation of pain levels. Progress against this action was being followed up at the next quarterly audit.

Staff said pain audits had improved patients' experiences. One pain audit showed that pain was not discussed at the patient's pre-operative assessment appointment. Now patients pain levels were identified pre and monitored postoperatively. We observed the preoperative pain check take place at a patient's pre-assessment appointment when the patient was asked to identify their current pain level from 1(low) to 10(high).

The ward had access to a supply of discharge medicines for patients to take away.

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 Duchy Hospital did not participate in national clinical audits as published by the Healthcare Quality Improvement Partnership. However, within Circle Healthcare Group, any published national audits were shared to all sites from the corporate team.

Managers and staff conducted a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits. Incidents and patient outcomes were discussed in detail which included discussion at clinical governance committee meetings.

Staff ensured that patients care was safe and effective through a combination of patient feedback, auditing, visible management across the hospital, observing and listening to situations throughout different departments and staff feedback.

The Duchy Hospital held quarterly resuscitation committee meetings, where audits, incidents and the reports of the unannounced resuscitation scenarios and sepsis management scenarios were discussed. The unannounced scenarios were conducted by an external training company and scored from 1 to 5 (1 - poor to 5 - outstanding). The outcome of the resuscitation scenario on the 12 December 2022 was scored a 4 which identified the scenario was managed well overall.

Outcomes for patients were positive, consistent, and met expectations, such as national standards. Managers and staff used the results to improve patients' outcomes. Patient reported outcome measures (PROMs) data had improved over time, for example, the Oxford Knee score. Higher pre-operative (pre-op) scoring often led to lower average health gains for patients. This was true of the Duchy Hospital, who had higher knee pre-op scores than the Circle Health Group average for 2020-2023. In 2020 and 2022 Duchy Hospital posted a lower average health gain for the Oxford Knee score than the Circle group average. In 2023 this changed as Duchy hospital posted a higher health gain than the Circle average, despite having a higher average pre-op score.

Good

Surgery

In 2022 Duchy Hospital participated in a joint replacement project which looked at improving outcomes and reducing length of stay. Duchy Hospital helped pilot a new day case pathway and saw an average length of stay reduction of 0.9 days per joint replacement patient. This was demonstrated in the 2023 average health gain, where Duchy Hospital were above the Circle Group average.

The service was accredited by the association for perioperative practice (AfPP) in December 2022. AfPP supports theatre nurses, operating department practitioners and healthcare assistants through its standards and guidance on best practice.

The service was reaccredited through the Joint Advisory Group (JAG) on gastro-intestinal endoscopy on the 1 September 2023. Through participation in this accreditation the service had enrolled on an ongoing programme of service and quality improvement.

The British Spinal Registry (BSR) was a consultant led registry. Only participating spinal consultants could submit and view their data to this registry. There was no statutory, or regulatory requirement to submit data to the BSR. However, in follow-up to the getting it right first-time spinal programme, Circle Health Groups (CHG) medical director wrote to all spinal surgeons to advise that all surgical spinal interventions were to be recorded on the BSR, along with outcomes at six weeks and six months. Administrative support to facilitate the submission of the consultant's data, where required, would be provided by the CHG hospital. The outcome data was discussed at the spinal surgeons' individual biannual reviews.

National joint register certification for data submission and quality confirmed was achieved by the hospital from 2021 to 2023.

Multidisciplinary working

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

Doctors, nurses, and other healthcare professionals worked together as a team and held multidisciplinary meetings to benefit patients and provide good care. Involvement of the multidisciplinary team was documented within patients records we reviewed.

Multidisciplinary attendance was present at the 9.30am activity meeting and in the twice daily clinical safety huddles. Staff worked across health care disciplines when required, for example, surgeons and anaesthetists worked closely with the nursing staff.

Staff worked closely with safeguarding, learning disabilities and mental health teams when supporting vulnerable patients.

We observed effective multidisciplinary teamwork throughout the patients' hip replacement surgery journey around information giving and medicines management.

The IPC team met with the local NHS Trust microbiologist quarterly; in addition, 24-hour microbiologist consultant cover was provided by the local NHS Trust.

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.

New staff attended the monthly corporate induction and local inductions were tailored to staff roles before all new staff started work. As part of the local induction process induction checklists, skills and competency documentation were completed. Staff competencies were assessed over a three-month period. The majority of staff competencies were accessed by staff online, where staff would self-assign the competencies and rate themselves. These competencies were then rated by the staff members manager.

A buddy system for new staff supported staff through their 3-month probation period.

The Power BI electronic resource was a live database for all professional registration and membership of staff members employed by Circle Health Group. This database alerted staff at 30 and 90 days prior to their registration or membership expiring to renew. The Duchy Hospital was compliant with memberships and registration renewals in the last 12 months.

Managers supported staff to develop through yearly, constructive appraisals of their work. The appraisal target was 90% across the Circle healthcare Group. To-date, 87% (two theatre staff) to 100% of nursing staff had an appraisal in 2022/23.

Consultant appraisals were recorded on the consultant database which flagged amber one month before expiry of the appraisal. As of the 14 November 2023 98.78% of consultants' appraisals were completed. Consultants biannual review compliance was 100%.

Medical staff could access training via e-learning and also at designated sessions, for example, new equipment training and resuscitation training. Additional training was agreed and provided if medical staff requested this support.

Resident medical officers were allocated a consultant mentor who they had met with occasionally and their appraisals were completed through the locum agency.

Monitoring of prescribers' practices took place; resident doctor's prescriptions for antimicrobials were reviewed and discussed with them. Individuals and the teams monitored data and fed back for antimicrobial stewardship on prescribing practice and prescriber level. Discussions also took place at medicines management governance meetings, clinical governance meetings and infection, prevention, and control meetings.

All lists where sedation was required were administered by the endoscopist or anaesthetist, supported by an operating department practitioner (ODP) or anaesthetic nurse. These registered staff had skills in airway management and monitoring of patients who had conscious sedation and were also recovery practitioners. ODP's within anaesthetics undertook competencies which were signed off by an experienced practitioner who had the support for learning in practice (SLiP) qualification.

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 which included specialist training for their role.

A staff training matrix included all staff groups and identified the training they were required to do.

Staff learning and development needs were supported by the training coordinator and resuscitation lead who worked 10 hours within this role. This person had completed a 'train the trainer' course for the deteriorating patient and venepuncture. Other training provided in-house by identified staff included intravenous medication training and basic life support training.

An external provider provided immediate and/or advanced life support training sessions. Staff with the advanced life support (ALS) qualification were identified by badges on their uniforms and were based in theatres, recovery, and the ward. Training statistics confirmed eight designated staff had completed adult advanced life support training, 96.8% (30 staff) had completed adult basic life support training and 83.7% (36 staff) had completed adult immediate life support training.

The IPC lead had 22 hours allocated to this role, had completed the IPC Circle Healthcare training, and was currently waiting to attend IPC funded training.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified poor staff performance promptly and supported staff to improve.

Students also had placements at the hospital as part of their university course. We received positive feedback from students about their hospital placement.

Seven-day services

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

Consultants visited their ward patients daily, including weekends and provided on-call support during out of hours periods.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Resident medical officers were present within the service 24/7.

The physiotherapy department provided a seven-day service. When there was an increased patient volume at weekends staff said they increased weekend cover to ensure patient's physiotherapy care needs were met. This was planned at the weekly activity meeting a week in advance. There was no physiotherapy service provided for out of hours.

There are no members of pharmacy staff routinely present at the weekend or out of hours. Pharmaceutical advice was available during pharmacy opening hours 09.00hrs - 17.00hrs Monday to Friday. However, in an emergency the Duchy Hospital pharmacist could be accessed.

Discharge prescriptions were dispensed in advance. The ward out of hours discharge prescription cupboard had pre-labelled medicines available for supply should the discharge prescription be written after pharmacy opening hours. The ward staff followed dispensing prelabelled medication processes. Private prescriptions were available for insured and self-pay patients.

Staff could access the out of hours microbiologists at the local NHS trust; rotas were distributed to all heads of department monthly.

Good

Surgery

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on ward.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

The patient's preoperative assessment identified the patient's potential fitness for the proposed surgery. Baseline monitoring was completed, for example, weight, blood pressure, allergies, and current medicines regime.

Patients were provided with information to inform them prior to their test or surgery, for example, receiving a blood transfusion, understanding blood pressure, smoking, and cholesterol, eating, drinking, and fasting before your procedure.

Clear guidance advised patients of the risks and how to avoid them through lifestyle changes. For example, the smoking leaflet offered smoking alternatives, how to quit and risks to friends and family.

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.

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. We observed four patient journeys through theatre and noted frequent repeated checks were made against each patient's consent at each stage of their journey.

The cosmetic surgery audit (September 2022 until September 2023) confirmed 100% compliance. This audit confirmed evidence of a two-stage consent process and a two-week cooling off period prior to surgery.

Quarterly consent audits identified 100% compliance.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Training statistics confirmed that 100% of staff identified to complete consent training had done so.

Training statistics confirmed that 98.7% of all staff had completed Mental Capacity Act and Deprivation of Liberty Safeguards training.

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.

Good

Surgery

One staff member said they did not know where to access the Mental Capacity Act and Deprivation of Liberty Safeguards policy.

Is the service caring?

Good

Compassionate care

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

Observations of staff interactions with patients confirmed that staff respected patients' privacy, were respectful, treated them well and with kindness and took time to interact with them. Staff were discreet and responsive and interacted with patients and those close to them in a respectful and considerate way.

Staff understood and respected the personal needs of patients and how they related to care needs. We spoke with 11 patients who said they had excellent care and spoke highly of the staff and how hard they worked.

Staff followed policy to keep patient care and treatment confidential.

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 and complex needs.

Collection of patient feedback was through the admitted care families and friend test (FTT) questionnaire. Overall patient satisfaction from November 2022 until October 2023 was between 94.1% to 100%. One example of feedback collected as part of the survey was, 'My hospital experience was actually enjoyable! Astonishing, really, as I was a little apprehensive about my minor op. The staff were ALL lovely and so professional.'

The FTT surveys highlighted new areas for improvement identified in the survey action plan. For example, Patients had long waits for surgery when they arrived early in the morning; in response the hospital worked with consultants for further staggered timings and the progress to-date was the introduction of a later admission times to the ward. The action plan confirmed this work continued with an expected review date of 31 March 2024.

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; chaperones were available when requested.

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 supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Good

Surgery

Patient feedback from the September 2023 friends and family test survey confirmed how supported they had felt during their stay at the Duchy Hospital, for example, one patient's comments were: 'excellent from start to finish. Everyone was attentive, kind and understanding. The level of service and care was excellent. In all my 80 plus years this is the first major surgery I've experienced, and I can only say that I felt safe, calm and confident throughout.'

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 and supported patients to make informed decisions about their care. Staff talked to patients in a way they could understand, using communication aids where necessary. Clear communication of options was discussed with the patient whose understanding was checked throughout the discussion and questions answered. One patient said they had received an 'excellent package of care'.

Patients received information and could access a wide selection of information leaflets through a variety of sources. Patients received information at their pre-admission appointment which included surgical specific leaflets and anaesthetic leaflets.

Private patients received 'terms and conditions' guidance. Information about different package prices, payment, our rights to cancel and applicable refund was included.

Patients and their families gave feedback on the service and their treatment through the completion of friends and families questions. Patients feedback confirmed their satisfaction around the support staff provided. Patients described communication as clear, informative and death rates were identified prior to surgery.

Is the service responsive?

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 needs of the local population. The service provided both NHS and private care pathways and as such worked closely with the local NHS Trust. Saturday waiting list initiatives were introduced to increase surgical/endoscopy list through put.

A dedicated consultant led pre-assessment clinic had been implemented for high-risk patients, which had resulted in fewer cancellations on the day of treatment.

Patients who deteriorated and required level two post-operative care were transferred to the acute trust under the agreed service level agreement.

Facilities and premises were appropriate for the services being delivered. The service provided separate rooms and had no mixed sex accommodation. Patients were admitted into a room which included ensuite facilities.

Good

Surgery

Parking for 31 cars was based at the front of the hospital; whilst staff and consultant parking areas were located at the back of the hospital.

The staff dining area had temporarily been relocated to the hospital board room, the radiology department was temporarily relocated close to the ward as the hospital was undergoing some redevelopment in these areas. We saw the new radiology department which we were told was due to be commissioned the week after the inspection.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

Managers monitored and took action to minimise missed appointments. Managers ensured that patients who did not attend appointments were contacted.

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 service had identified lead persons for safeguarding, dementia, accessible information standards and mental health first aiders as a support for patients and staff.

Mental health and psychological support could be accessed easily 24/7.

All but one staff member had completed training in dementia awareness (92.3%) and one staff member had completed the Dementia UK Support course.

All staff had completed training in equality and diversity. One new staff member and one consultant were to complete the Oliver McGowan training on learning disability and autism.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff said patients and their families would be given additional time and support where needed and the start of this process commenced when the patient attended their pre-assessment consultation with the nurse. Where patients did not meet the acceptance criteria for the service their referrals were sent back to the referring clinician.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and communication passports.

Staff had access to communication aids to help patients become partners in their care and treatment. They understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss, for example, patients with a hearing loss could access the hearing loop to aid their communication.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service could access information leaflets available in languages spoken by the patients and local community.

Good

Surgery

In response to patient feedback 'You said, we did' information was displayed throughout the hospital. Some of the initiatives included new WIFI system installed throughout the hospital and new menus developed with additional choices such as vegan and vegetarian options.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

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.

A range of clinics were offered through the e-referral system, a service which allowed the patient to decide where to receive treatment.

The NHS choose and book programme was accessed by patients via their GP or through contact with the NHS telephone appointments line. The service had a full time NHS administrator who managed these bookings. Choose and book patients were triaged before they were accepted; if treatment could not be provided the patients GP was informed.

In January 2023 an NHS administrator was made responsible for all NHS pathways which included monitoring of the referral to treatment (RTT) daily. A weekly meeting with the NHS administrator and patient administration manager identified concerns and flagged escalations to the senior management team. This information was discussed at the Tuesday daily communications meeting.

The extended activity meeting every Thursday was where patients of concern were reviewed and where the team reviewed the next four weeks to ensure plans were in place and appropriate equipment available.

Consultants put priorities on booking forms, and these were added into the electronic application. Patients were listed first by clinical priority. Private patients were listed by who had waited the longest and, for NHS patients, from their referral to treatment time pathway status.

In January 2023 a specific NHS administrator was identified to be responsible for all NHS pathways, and to ensure the referral to treatment was monitored and updated daily. A weekly meeting between the NHS administrator and patient administrator manager identified any concerns and flagged any escalations to the senior management team. These were discussed every Tuesday during the daily communications meeting. Identified patients of concern were discussed at the weekly extended activity meeting to ensure the patients pathways were not breached.

In England, under the NHS Constitution, 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.

The hospitals referral to treatment (RTT) pathway data from April 2022 to March 2023 total pathways for the surgical specialities ranged from 328 (December 2022) to 402 (April 2022). The March 2023 data identified 361 total pathways. The data provided over this time-period confirmed the highest breaches fell within the 18-week plus pathway target.

There had been 2814 admissions from April 2022 until March 2023. This information when broken down into elective NHS and private patients on the ward were 347 and 550 patients respectively.

Good

Surgery

Day case activity for NHS and private patients was 493 and 1424 patients respectively.

From January 2022 until October 2023 there were seven readmissions to the service within two days of discharge.

Private referrals were either from GPs, opticians, physiotherapists, or consultants. Patients could self-refer. Staff said private referrals were not triaged, the patient saw the consultant first and when listed for surgery they would be called for a pre-admission appointment by the nurse. Staff said that the pre-admission appointment could be either via telephone or in person. Generally, the patients with the most complex needs were seen in person at the pre-admission clinic.

Clear elective surgical admission criteria (v1.1) and the Pre-Operative Assessment (v3) guidance instructed staff as to the patients' suitability for admission to the hospital.

On the day of surgery all patients were reviewed by their consultant and anaesthetist and listed for theatre in order of clinical priority.

Should a patient require return to theatre this was prioritised during the working day and the 'Stop the Line' discussions took place in the elective lists to prioritise a return to theatre patient. If a patient required a return to theatre out of hours the on-call theatre team, anaesthetist, and surgeon, on call manager and on call clinical person were contacted and the patient would undergo the appropriate procedure.

Following the inspection, the provider confirmed that staff completed post-surgical patient follow up calls.

The service moved patients only when there was a clear medical reason or in their best interest. Staff supported patients when they were referred or transferred between services. Managers monitored patient transfers through the incident reporting framework so that learning and changes to practice were identified should a patient require an emergency transfer to the NHS Trust.

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

Managers and staff worked to make sure patients did not stay longer than they needed to. Managers and staff worked to make sure that they started discharge planning as early as possible. Staff planned patients' discharge carefully, particularly for those with complex health and social care needs.

Managers worked to keep the number of cancelled appointments to a minimum. When patients had their appointments or operations cancelled at the last minute, 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. The service included patients in the investigation of their complaint.

Patients, relatives, and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Good

Surgery

Systems were in place which ensured an independent review of complaints and where the complainant remained unsatisfied with the hospital response, they were referred to the Ombudsman (NHS Patients) or the independent sector complaints adjudication service to ask for further review.

Staff understood the policy on complaints and knew how to manage them.

Managers investigated complaints and identified themes. We reviewed three complaints and saw the complaints process was followed and learning was identified from two complaints.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice.

The complaints register for surgery listed 61 complaints from 1 November 2022 to 1 October 2023. Of these, 13 complaints were ward related, and one complaint theatre related.

Is the service well-led?

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 registered manager and director of clinical services were both new to their roles. They were supported by the director of operations, Medical Advisory Committee chairman, consultant staff and senior management teams within the hospital and the Circle Healthcare Group network.

The registered manager had previously been the Director of Clinical Services at the hospital and had been promoted into this role. Staff told us they felt supported by the management teams and could share their thoughts with the senior management teams.

The organisational charts identified senior support throughout the departments of the hospital. Three clinical service managers covered theatre, outpatients, radiology, physiotherapy, health screening and safety, the ward and pharmacy.

A sales and marketing manager, quality and risk manager are members of the senior leadership team who were supported by an executive assistant / employee compliance coordinator.

We saw evidence and staff told us they were encouraged and supported to develop within their roles.

Good

Surgery

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. 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 2023-2024 hospital strategy identified four categories: patient experience, engaged staff, clinical outcomes, and optimal value. Each category was underpinned by a strategic objective, for example, clinical outcomes – to be the hospital of choice provider for patients across North and West Yorkshire. Staff and consultant feedback and the outcome of discussions from the 2023 leadership awayday informed the strategy. The strategy was discussed during monthly leadership meetings.

The corporate vision and strategy identified the company's aims over the next two years. The four areas included: People - being aligned, focused and responsive, Quality and Infrastructure and technology. In respect of the Duchy Hospital, we saw some of these areas were being implemented, for example, technology – WIFI coverage in all areas and the upgrading of hospital facilities. It was also evident that staff were supported to develop their skills and knowledge which in some instances had resulted in promotion.

The Circle Group philosophy was launched in June 2021 which identified four principles and four values.

The Circle operating system (COS) included the corporate values which were implemented at the hospital. Road shows encouraged discussions with staff. Discussions with staff confirmed they were aware of this new system, and they said they felt confident using the 'stop the line' and 'SWARM' approaches associated with COS if a concern or when a safety issue was raised.

Hospital values were aligned with the corporate values. The hospital values were reviewed by the leadership team in February 2023 and again following feedback from the management teams. Staff confirmed an awareness of the hospital values and involvement in their development.

Individual teams had since built their objectives and shared their choices with the senior management team. Staff had developed their departmental values which were displayed on notice boards outside departments.

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.

At the last inspection improvements had been made in the hospitals approach to the Workforce Race Equality Standard (WRES) but the hospital leaders acknowledged they were not yet fully compliant with the requirements. The WRES was implemented, managed, and monitored corporately by the human resources team. At this inspection the service was fully compliant against the WRES.

Staff said the culture had improved within the service and praised the support provided by the management teams.

Staff could access well-being initiatives, Pilates and counselling provided through Circle Healthcare. Pilate sessions took place at the Duchy Hospital which staff could access.

A freedom to speak up guardian (FTSUG) was available for staff to approach. This person had completed the corporate e-learning training and also attended an annual conference. A national FTSUG lead within the Circle Healthcare Group, the management team and the wider Circle Healthcare group had supported this person in their role.

FTSUG drop-in sessions, lunchtime walks, talks in the summer and daily communications kept staff informed. September 2023 was 'speak up' month. Staff were aware of this person and felt comfortable approaching them if required.

Staff said they were able to develop within their roles and gave examples of how this development had happened, for example, one healthcare assistant had been supported by the hospital to undertake their nurse training.

Staff said behaviour and performance was addressed and gave recent examples and the processes followed to address these concerns.

The relationship between Circle Health Group (CHG) and consultants was clearly identified through practising privileges agreements and adherence by CHG to the Competition and Markets Authority Order (the "CMA Order"). This regulated the relationships between private hospital groups and consultants who had practising privileges or treat private patients or refer them for tests at group facilities.

Fraud, Bribery and Corruption guidance advised staff on how to recognise and deal with fraud, bribery, and corruption issues. Potential red flag or risk scenario's advised staff of what to look for should they have concerns.

Staff said relationships with the local NHS Trust had continued to improve due to the shared working during the Covid 19 pandemic.

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 implemented the Circle Operating System (COS) framework. Staff said the framework encouraged a ward to board approach so that feedback flowed both ways. The governance assurance framework confirmed this approach.

Staff confirmed involvement in how the service was monitored through audit processes of which feedback was shared at staff meetings and through email correspondence.

Staff said the current management team encouraged open communication pathways.

The monthly governance bulletin for staff was circulated via email to staff and consultants. Staff also received feedback on safety issues and audit outcomes, for example, national early warning score scoring and pain scoring chart audits.

Quarterly Medical Advisory Committee (MAC) meetings took place where regular clinical updates and new consultants applications were discussed and agreed. The MAC chair also attended monthly hospital governance meetings.

We reviewed six consultants' personnel files and saw all checks present. Information for the consultants was stored electronically and when expiry dates of appraisals, indemnity and other checks were due this flagged on the system a month before renewal and consultants contacted. Consultants also had a biannual review session with the registered manager where discussions such as individual performance or outlier status were discussed.

Staff described improvements in staff attendance at basic and immediate life support training sessions since the 2017 inspection and some nursing staff were also trained to an advanced life support level.

Service level agreements were in place with external providers to support their services, for example, pathology, microbiology, and patient transfer agreements.

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.

The Circle Operating System (COS) was launched in March 2021. This system empowered staff to work together to be safe and effective and recognised that everyone had a responsibility to contribute towards this goal. Staff described two of the approaches used which included 'stop the line' when the activity was ceased, reviewed, and managed through the incident framework. The 'swarm' was where staff problem solved at the time and implemented changes until the issue was resolved. Staff said the teams had embraced this approach and met as a team whose discussions included 'what we can do differently'.

A new management system called 'Radar' captured incidents, complaints, safety alerts, audits, National Institute for Health and Clinical Excellence guidance and the risk register. Reminders were set up on the system to remind the team when the action and / or review was due. All staff could access this system and could view information pertaining to their own departments. Editing of this information was undertaken by either the head of department or assigned person. Staff training in the use of the system commenced on the 2 November 2023. Staff said the new system ensured that the team had a complete overview of activity within the service.

The director of clinical services responsibilities ensured all safety alerts were reviewed, local action taken where relevant and where actions could not be taken, mitigating plans were recorded in the local risk register. In addition, staff could access policy guidance for the management of safety alerts and national guidance.

The director of infection, prevention, and control (DIPC) and an infection, prevention, and control (IPC) lead led on IPC issues. Departmental IPC link staff completed IPC training, had access to an IPC link practitioner handbook and were allocated eight hours monthly for this role. The IPC strategy (2023-24) had informed department strategies. Corporate IPC meetings took place each quarter, the last one was September 2023.

Regional and company compliance to surgical safety audits were discussed at the director of clinical services meeting and the quality and risk managers meetings which allowed the hospital to benchmark against other hospitals within the Circle Health Group.

The hospital risk register identified risks to the service which were colour coded red, amber, green to signify the level of risk, red being the highest risk level. Discussion with different staff groups confirmed their awareness of the risks in their areas. Each department displayed their risks on an information board outside each department.

Quarterly review of hospital and departmental risks or when the risk level changed took place. The senior management team (SMT) reviewed new risks to ensure controls and mitigation were in place and identified the person responsible for the risk. The review of hospital risks took place one month after departmental risk reviews. Monthly reports informed the senior management team of any changes on the risk register. Risks were discussed at the appropriate committee meeting. The hospital risk register was discussed at SMT, clinical governance committee, the medical advisory committee and at the regional meeting with the regional team.

At inspection we escalated two potential risks to the management team. The first risk related to the pipes from the radiators projecting from the radiator cover which potentially could burn a patient should they fall and hit the radiator. Following the inspection this risk was added to the risk register.

The second risk which was on the risk register related to some beds not having cot sides. Replacement beds with cot sides were delivered in December 2023.

Performance was monitored through identified annual audit schedules. We have referred to the several types of audits throughout the report. From the audit data reviewed we had no concerns in this area.

Monitoring of assurance systems and performance measures by the clinical governance team took place. Key performance indicators and outliers were reviewed to see why they were an outlier. As part of this assurance process the hospital monitored wound infection data and found that when a stat dose of antibiotics was given as a preventative measure this flagged as an infection even if there was not one. Ongoing monitoring was now in place to capture any other themes.

Suspected sepsis events were recorded on the corporate incident reporting system as a patient deterioration / cardiac arrest and then followed up onsite to determine the level of harm. These events were reported as part of the patient safety incident response group; initial learnings were shared at site and corporate learnings shared to other sites through the clinical update.

A patient led assessment of the care environment took place on the 1 November 2023; a good overall rating was awarded for the patient environment and catering. The action plan included actions on car parking and some external painting.

Staff said they received feedback about hospital performance through audit processes at staff meetings and through information shared by the hospital on their intranet system. We also saw audit outcomes, risks, patient feedback, and new patient information were some of the topics discussed and communicated through meeting minutes from various meetings. These included infection, prevention and control, clinical governance committee and medicines management governance meetings.

Three meetings had taken place with the NHS Trust throughout 2023. These meetings were not minuted.

Guidance and plans were in place which identified how the hospital would respond to unexpected events.

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.

Good

Surgery

There was no theatre management information technology system in place; all equipment board entries were documented and stored with the patients notes.

Staff completed information governance training, in 2022 – 2023 98.9% of staff had completed this training.

The registered manager had overall responsibility for the submission of statutory notifications to the Care Quality Commission.

Private healthcare information network data was submitted via consultants' teams.

The service had NHS digital data security and protection toolkit accreditation.

In May 2023, Circle Health Group (CHG) introduced the My Clinical Outcomes (MCO) web platform for digital Patient Reported Outcome Measures (PROMs). The hospital used a digital platform for patient reported outcome measures. This ensured patients had better accessibility to their results. Also, clinical teams had real time access to data to inform the need for follow up.

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 April 2023 'b-Heard survey results was completed by 61 of 89 (68.54%) of staff; a slight decrease on staff participation at 77.53% seen in the March 2022 survey. Comparison against the March 2022 survey showed an improvement in seven of eight areas. Areas to celebrate and improve were identified, for example, areas to improve included, fair deal, my manager and leadership. In response the action plan identified the areas which required improvement, with either timescales identified, or progress made to-date. One initiative due to start in January 2024 aimed at staff and consultants was the introduction of breakfast for questions and answers with the executive director.

The hospital had achieved two-star accreditation which was an improvement from 2022 when it was rated one star. The highest level of accreditation the hospital could achieve was three star.

Theatre and ward staff meeting minutes confirmed staff were kept updated of events. A standard agenda was in place. Some of the topics included incidents, complaints, the b-Heard staff survey outcome, patient experiences, clinical outcomes, and the risk register status for their area was discussed at the September 2023 meeting.

The theatre newsletter dated October 2023 updated staff against some areas discussed from the staff meeting, for example, the risk register, engaged staff and patient experience.

Patient Led Assessment of the Care Environment (PLACE) auditing had taken place recently. The outcome of the 2022 PLACE audit scores ranged from 91.88% (Disability) to 100% (Cleanliness). The service worked with external providers and previous patients who undertook this audit annually. The PLACE action plan identified 19 actions and dates for completion of these actions; five actions were completed.

Quarterly patient experience trending reports took place and were presented at the patient experience meeting. The last report looked at patients experiences for July, August, and September 2023. The majority of areas identified within the quality health reports had improved with the exception of one area, quality of care, which showed a slight decrease to 96% in September 2023; previously this had been 99% in July and 97% in August. Patient satisfaction for patient groups ranged from 96% to 100% during the quarter.

The patient satisfaction survey action plan identified six actions which related to specific departments. Three related to ward experiences, for example patients having long waits on day of surgery. To improve this the hospital had progressed towards the introduction of morning and afternoon admissions.

The nomination of a colleague's award were presented on a monthly basis and the summer sports day for all staff.

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 and participation in research.

At the last inspection there had been many improvements in governance, leadership, staff and public engagement and staff morale and culture but many of the new processes and initiatives were still in their infancy. The hospital leaders knew they had more to do to ensure they were embedded, and improvement sustained. At this inspection we observed ongoing improvements had taken place and were sustained. Governance, performance, and risk processes were now embedded and evidence of this was seen through the performance dashboard, audit and monitoring processes and feedback from staff and patients.

The service had identified a Circle Operating System (COS) champion whose responsibilities included role modelling Circle Health Group's behaviours and ways of working, driving engagement and continuous improvement in each area. The safety champion at the Duchy had helped improve compliance across departments. The safety to surgery improvement programme was ongoing, and the team met to discuss performance and ways to improve the safety in the theatre department and share across the hospital and wider.

Recent capital investment in the hospital environment and equipment was agreed. The refurbished radiology department was nearing completion and new patient beds with cot-sides were purchased and were delivered in December 2023.

The catering service had recently acquired five-star food hygiene accreditation status.

The service confirmed ongoing accreditation in a number of areas, please refer to the patient outcomes section for the areas pertinent to this hospital.

Aseptic Non-Touch Technique gold accreditation was awarded to the Circle Health Group valid until August 2026.

VTE Exemplar Centres Revalidation 2023, Circle Health Group was awarded in May 2023.

The patient led assessment of the care environment (P.L.A.C.E) in November 2022, identified the outpatient public rest rooms looked tired and dated and the basin unit was chipped. The refurbishment started in September 2023 and when the (P.L.A.C.E) was undertaken in November 2023, the refurbishment was completed. The patients were pleased that this had been completed and they had made a difference. Progress of the P.L.A.C.E actions were discussed at committee meetings which included clinical governance and the patient experience meetings.

Good

Surgery

A quality improvement programme called 'Patient Voice' encouraged patients to become involved in-service developments. A supporting handbook gave the background of the hospital and some abbreviations which might be used in meetings. Staff confirmed patient involvement in various meetings, for example patients attended clinical governance committee meetings, patient participation groups and were involved in the patient led assessment of the care environment yearly audit.

Staff shared an example which showed how they had worked together to resolve a problem on the ward area. The new clinical services manager first team meeting was in August 2023. This allowed staff the opportunity to have their voices heard. Following this meeting the CSM met with staff individually to give them the opportunity to raise concerns or identify areas to improve. In response to this feedback the following were introduced: the safer staffing framework, team building through the monthly team meetings and assessor / supervisor training updates.

Good

Outpatients

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

Is the service safe?

Good

Mandatory training

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

Staff kept up to date with their mandatory training. Mandatory training completion for the outpatients' service in 2022-23 was 100%. Staff had time to complete mandatory training. For new starters, a 3-month window was allowed.

Mandatory training was comprehensive and met the needs of patients and staff. Staff in outpatients completed mandatory training on subjects to support them in their roles including mental health, learning disability, dementia, and autism awareness. Advanced, intermediate, and basic life support (depending on role) patient deterioration, anti-bribery and fraud, aseptic non-touch technique and conflict resolution were further examples included in mandatory training. Staff explained how their training was helpful in preparing them for their roles.

A training coordinator oversaw mandatory training for all staff. A training matrix including all staff groups identified the training staff are required to complete. The training coordinator discussed outstanding training with clinical services managers. Training attendance was recorded, and staff receive an alert email at three and six months prior to expiry of their training. Managers monitored mandatory training and alerted staff when they needed to update their training.

For other detailed findings relating to mandatory training refer to Surgery, Safe, Mandatory training.

Safeguarding

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. The hospital confirmed that one safeguarding concern was reported in the previous 12 months, but no safeguarding incidents were raised within Outpatients during the period May 2023 to October 2023. Current safeguarding policies for the provider were available on-line and accessible to staff.

Good

Outpatients

Staff followed safe procedures for children visiting the outpatient's department. The only children in the department were those attending with an adult as the service did not treat children. The service had up to date safeguarding policies in place.

The director of clinical services was the safeguarding lead for the hospital and liaised with the provider's corporate safeguarding lead. Safeguarding issues were discussed at team meetings. A safeguarding committee meeting for the hospital was held quarterly. The hospital also attended a North Yorkshire private providers safeguarding meeting twice yearly. The safeguarding lead for the hospital provided advice to staff if they were unsure about any aspect of the safeguarding process and a debrief took place after a safeguarding event.

Staff received training specific to their role in how to recognise and report abuse. All eligible staff had completed safeguarding vulnerable adults' level 1, 2, 3 and safeguarding children level 1 and level 2. The registered manager, the director of clinical services and the safeguarding lead had completed level 4 safeguarding training. Clinical staff including safeguarding champions completed level 3 training. Non-clinical staff received level 1 or level 2 training dependant on their role. All eligible staff had completed 'prevent' training. Prevent training aims to ensure the safeguarding of children, adults, and communities from threats of terrorism.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

For other detailed findings relating to Safeguarding refer to Surgery, Safe, Safeguarding.

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.

All areas in the outpatient's department were visibly clean. Clinical areas were clean and had suitable furnishings which were clean and well-maintained. The waiting areas and clinic rooms had chairs made with a wipeable material to promote effective cleaning. Furnishings throughout the outpatient's department were well-maintained. A daily cleaning schedule was up to date for November 2023 and demonstrated all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff received training in infection prevention and control. The hospital monitored its effectiveness in reducing the risk of spreading infections.

An Infection prevention and control strategy for 2023-24 is in place for the hospital which followed the provider's corporate guidance. Infection prevention and control audits were completed, audit outcomes are escalated to the registered manager and staff receive immediate feedback. We reviewed the results of the quarterly IPC principles and practices and hand hygiene audits and found 100% compliance from May to Oct 2023.

Staff disposed of clinical waste safely. The hospital follows decontamination guidance. All rooms were provided with clinical waste, general waste, and sharps bins. Sharps bins were labelled and in date. Flexible endoscopes were not used in the outpatient's department; the department used only single use equipment, which followed the provider's corporate guidance.

Good

Outpatients

For other detailed findings relating to cleanliness, infection control and hygiene refer to Surgery, Safe, cleanliness, infection control and hygiene.

Environment and equipment

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

The outpatient's department had suitable facilities to meet the needs of patients on the first floor and the physiotherapy department was located on the second floor of the hospital accessed by stairs or by lift. The service had suitable facilities for the use of patients and their relatives when visiting the hospital. The department had nine clinic rooms available for consultant use when seeing patients and a minor treatment room for procedures under local anaesthetic only. The design of the environment followed national guidance. We found there were no carpeted areas in the outpatient's department or elsewhere in the hospital.

The service had sufficient and suitable equipment for the care of patients. The investment in premises and equipment was supported by the hospital becoming a member of the Circle Health Group. The fire escape had been upgraded and although some other works were in progress including the outpatient toilets, we observed this did not disrupt the functioning of the outpatient's department.

The outpatients service equipment calibration records confirmed calibration was complete for 2023. We also saw evidence of portable appliance testing and equipment servicing for 2022-23.

Circle Health Group had invested in equipment, for example, the Ophthalmologist requested new equipment which was provided. The items of equipment we checked were in date for servicing. Fire safety equipment checks were in date. Staff carried out daily safety checks of specialist equipment.

For other detailed findings relating to Environment and equipment refer to Surgery, Safe, Environment and equipment.

Assessing and responding to patient risk

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

The service assessed and responded safely to patient risks. A member of the outpatient's department participated in a safety 'huddle' of the hospital-wide resuscitation team twice daily where risks were reviewed and any additional risks for outpatients, for example from the minor procedures list, were considered and mitigated. Each member of the team was assigned a specific role. The pre-operative assessment team held a daily 'huddle' to review activity. The service applied inclusion and exclusions criteria, for example exclusions included a body mass index (BMI) of over 40, sleep apnoea and certain comorbidities. The pre-operative face to face meeting included a health questionnaire with home and social circumstances reviewed and a joint pre-op assessment with the physiotherapy team.

Staff responded promptly to any sudden deterioration in a patient's health. Although acutely unwell patients rarely attended the outpatient's department, staff were trained appropriately to respond. Resuscitation scenarios were completed every three months. Emergency resuscitation trolleys were conveniently located in easy reach of all areas of the outpatient's department, including the second-floor physiotherapy department. Resuscitation equipment was checked daily, and these checks were recorded.

Staff resuscitation training records confirmed staff had received appropriate basic, immediate, or advanced life support training with overall compliance of 90.2%.

Consultation rooms and patient toilets had emergency call bells in place.

Staff completed risk assessments for patients during clinic appointments when required. The completion of risk assessments was not required for each patient visiting as an outpatient. A safety checklist was completed before each minor procedure which followed the World Health Organisation's surgical safety checklist. The patient records we reviewed showed appropriate risk assessments were completed.

For other detailed findings relating to Assessing and responding to patient risk refer to Surgery, Safe, Assessing and responding to patient risk.

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, agency, and locum staff a full induction.

The outpatient's department had enough nursing and support staff to keep patients safe. Managers adjusted staffing levels daily according to the needs of patients. Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

Staff worked flexibly across departments including outpatients to ensure all areas had safe staffing levels. Outpatients' clinical services were supported by nursing and support staff. Staffing levels and skill mix for each day were planned based on the type and number of clinics running and the number of patients attending. The clinical service manager regularly worked in the pre-operative assessment area and provided cover for clinics when required. Bank nurses covered evenings and completed the same level of training as substantive staff. The clinical service manager confirmed there had been no instances of outpatients' clinics cancelled due to staff unavailability. We reviewed staff rotas for the outpatients and physiotherapy departments for the most recent three months which confirmed these arrangements.

A number of medical consultants reflecting a range of specialties were granted practising privileges to practice in the outpatient department. We spoke with two medical consultants and two general practitioners who worked under practicing privileges and who were very positive about their relationship with the hospital outpatient's department. The hospital planned for 30 minutes for a pre-operative assessment by telephone and one hour for a face-to-face appointment. A resident medical officer (RMO) was located at the hospital and was available for advice when required.

Vacancies currently equated to 18 hours for registered nursing in the outpatient's department and recruitment was ongoing. Cover for annual leave and sickness is provided by existing staff working additional hours, by the bank staff and by the clinical service manager carrying out clinical shifts. The Outpatients department could also use staff from the inpatient ward to provide cover.

For other detailed findings relating to staffing refer to Surgery, Safe, Nurse staffing and Surgery, Safe, Medical staffing.

Records

Good

Outpatients

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 staff could access them. We reviewed the records of 6 patients which confirmed the information was complete. We saw completed consent records, risk assessments including allergies, treatment plans, medicines, and medical histories. Entries were legible, dated, and signed. In the 12 months previous to our inspection, the hospital had undertaken an exercise to address incomplete documentation using an audit to ensure accuracy and legibility and contemporaneous clinical records were subject to ongoing audit. The audit of patient records for the most recent six months showed 100% compliance.

When patients transferred to a new team, there were no delays in staff accessing their records. The hospital had recently undertaken an exercise in extending its contemporaneous notes so that records of patients receiving care and treatment in outpatients were integrated with the patient's main medical notes. This meant consultants had sight of progression notes and for example, physiotherapy had sight of consultation notes so that full medical notes were available in outpatients' clinics. Staff in the outpatient's department had access, without delays, to information on treatment and diagnostics carried out across the hospital.

Records were stored in hard copy and electronic form. An electronic patient appointment booking system was in use. Booking referral forms were kept in patient records. Records were stored securely. Within consultation and clinic rooms, notes were stored in locked cabinets. Consultation rooms had a mobile storage box which was used for confidential storage of patient notes when clinics were in use. Records at reception were not accessible to patients or visitors.

For other detailed findings relating to Records refer to Surgery, Safe, Records.

Medicines

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

Staff followed current national practice to check patients had the correct medicines. Staff received training in the management of medicines and medical gases as part of mandatory training.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff reviewed patient's medicines at follow up appointments.

Staff completed medicines records accurately and kept them up to date. Staff completed medicines management audits for the outpatient's department. Medicine audit records for the most recent six months showed 100% compliance.

Staff stored and managed all medicines and prescribing documents safely. The outpatient's department stored medicines in the clean utility and medicines room. The room was clean and well-maintained although the room door was fitted with a bare wood panel, which may make it difficult to clean and decontaminate.

Room temperatures were monitored. Medicines stored in the refrigerator were temperature controlled. The temperature log for the most recent month showed all entries with 2-8 degrees C and room temps under 25 degrees C. A lockable metal cabinet was used to store flammable solutions. Oxygen was stored securely with a chain. No controlled drugs were stored in the outpatient's department.

Good

Outpatients

Staff learned from safety alerts and incidents to improve practice. Medicine safety alerts were shared with staff when relevant to their practice. Pharmacy staff took appropriate action from medicine safety alerts. The clinical services manager and clinical lead attended a quarterly medicines management meeting.

For other detailed findings relating to Medicines refer to Surgery, Safe, 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 raised concerns and reported incidents and near misses in line with the service's policy. The outpatient's department had reported 93 incidents in the past 12 months. The most recent serious incident was 18 months previously. The hospital had no never events in the past 12 months.

Staff understood the duty of candour. A nominated member of senior staff undertook duty of candour formally for moderate (or above) harm incidents. Staff were open and transparent and gave patients and families a full explanation if and when things went wrong. Duty of candour was incorporated within the hospitals incident reporting system.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff received feedback from investigation of incidents. Staff met to discuss the feedback and look at improvements to patient care.

The most recent serious incident which took place in the outpatient's department involved a patent collapse and had resulted in some learning being embedded; following which the afternoon resuscitation huddle was introduced. The hospital operated a 'stop the line' process, so that any member of staff could stop activity if they encountered a situation that potentially may cause patient harm. Staff shared examples of swarms that had taken place in outpatients. Swarms are examples of rapid responses to safety incidents.

Managers debriefed and supported staff after any serious incident and changes were made as a result of feedback. A senior manager was alerted when an incident is raised and undertakes to investigate the incident. Incident investigations and action plans are reported.

The hospital used an electronic system for incident reporting, which was aligned to its provider reporting arrangements. All staff, including bank staff had access to the incident reporting system. An incidents register was in place which was discussed at monthly governance meetings. The clinical services manager attended a hospital-wide incident review meeting, where incidents were reviewed, and trends analysed. A monthly governance bulletin for staff was produced quarterly and shared with staff, including consultant staff.

For other detailed findings relating to Incidents refer to Surgery, Safe, Incidents.

Is the service effective?

Good

Outpatients

Inspected but not rated

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 reviewed the hospital's policies related to care of people in outpatients which included safeguarding vulnerable adults, complaints, mental capacity, deprivation of liberty and restrictive practice. These policies were up to date and reflected national guidance from National Institute for Health and Care Excellence, the Nursing and Midwifery Council, the Office of the Public Guardian and more general guidance applicable to NHS patients.

The clinical governance meeting held monthly provided a mechanism for any changes to best practice and national guidance to be reviewed. An outpatient's consultant attended the quarterly meeting of the NICE advisory committee. We spoke with the consultant who confirmed that he was kept up to date through a range of mechanisms of changes to guidance which may affect clinical practice. The hospital completed audits of compliance with their outpatients policies, which were ongoing.

For other detailed findings relating to Evidence-based care and treatment refer to Surgery, Effective, Evidence-based care and treatment.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink. Including those with specialist nutrition and hydration needs. Patients we spoke with confirmed that food and drink of their choice had been offered to them during their visit to the outpatients' department.

For other detailed findings relating to Nutrition and hydration refer to Surgery, Effective, Nutrition and hydration.

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. Our review of patient records confirmed that staff monitored patient's pain levels during their visit to outpatients where this was relevant to the patient's treatment.

Good

Outpatients

The outpatient specialties included a pain clinic. The outpatient speciality spinal injection service was developed for the hospital in response to patient demand in the local area. The service recently relocated to a patient treatment room in the outpatient's dept. with excellent feedback from patients.

Patients received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately. Our review of patient records confirmed that pain relief was administered when needed. Pain management audits relevant to outpatients reflected the patient care pathway for the hospital with compliance results for the previous 12 months of 95% overall.

For other detailed findings relating to Pain relief refer to Surgery, Effective, Pain relief.

Patient outcomes

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

Outcomes for patients were positive, consistent, and met expectations. The patient satisfaction survey results for October 2023 reflected very positive patient comments for outpatients with shows a high proportion of patient's experience being very satisfied. Patient's expectations were being met or exceeded.

No national clinical audits were relevant to the hospital outpatient's department. The hospital did not collect patient reported outcome measures (PROMS) for outpatient services. However, following the inspection the provider confirmed that the hospital collected patient reported outcome measures (PROMS) for the patient pathway including outpatients' services.

Data was collected from patients as to their consultant outpatient experience and from May 2023 very positive responses were received in consultant feedback. For the outpatient's department, a schedule of monthly, quarterly, four-monthly, and annual audits took place and for the physiotherapy service local audits were undertaken to support review of the service. The clinical services manager prepared a monthly performance report.

The hospital undertook a comprehensive programme of repeated audits to check improvement over time. Managers shared outcomes from audits and ensured staff understood information from the audits. Managers and staff used the results of audit to maintain and improve effective patient outcomes.

Patient reported outcome measures for the physiotherapy department demonstrated improvement in patient health. My Clinical Outcomes was used to monitor patient reported outcome measures live for physiotherapy patients.

For other detailed findings relating to patient outcomes refer to Surgery, Effective, Patient outcomes.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff 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. Managers gave all new staff a full induction tailored to their role before they started work. Each new member of staff completed an induction.

Good

Outpatients

Managers supported staff to develop through yearly, constructive appraisals of their work. Each member of staff had completed an appraisal in the last 12 months. Consultant staff completed an appraisal with their employing organisation and practiced in the outpatient's department within their sphere of competence. Managers identified poor staff performance promptly and supported staff to improve.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge, including being allocated dedicated time for training. Managers made sure staff received any specialist training for their role. The Circle Health Group provided funding to support specific training needs.

The hospital supported students from university to undertake placements in the hospital and also arranged placements for college students who wanted work placements. These placements were supervised by experienced staff members.

Succession planning was in place and a nominated senior nurse provided backup for the clinical service manager when on leave.

For other detailed findings relating to Competent staff refer to Surgery, Effective, Competent staff.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. A daily meeting in the hospital was attended by a representative from each hospital department including outpatients. Each department familiarised with other staff including agency staff who were on duty that day in the hospital.

Patients could see more than one clinician involved in their care and treatment during their visit to the hospital. Where possible the hospital would arrange for the patient's diagnostic tests or physiotherapy to coincide with their next outpatient appointment. The hospital also shared examples of how multidisciplinary working with the local NHS hospital, community-based services and ambulance services had benefited patients.

For other detailed findings relating to Multidisciplinary working refer to Surgery, Effective, Multidisciplinary working.

Seven-day services

Key services were available to support the delivery of timely patient care.

The hospital outpatient's department usually operated six days per week. Outpatients operated morning, afternoon, and evening clinics from 8am to 8pm Mondays to Thursdays. On Fridays the outpatient's department closed by 6:30pm and on Saturdays by 2:00pm.

The physiotherapy department operated Monday to Friday 8am to 5pm and may provide inpatient provision at the weekend.

For other detailed findings relating to Seven-day services refer to Surgery, Effective, Seven-day services.

Good

Outpatients

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas. Staff assessed the patient's health at each appointment and provided for individual needs to support a healthier lifestyle.

In reviewing patient records and in speaking with patients we found that topics to support health promotion and health education needs were reviewed and discussed along with care and treatment. For example, alcohol risk assessments and physiotherapy pre-op assessments were included in surgical pre-op assessments for some patients. Physiotherapy pre-op assessments took account of the patient's socio-environmental needs.

The hospital displayed relevant information promoting healthy lifestyles and support available in areas accessible to patients. The provider's website contained information explaining the relevance of treatment options including explanations of benefits to patients.

For other detailed findings relating to Health promotion refer to Surgery, Effective, Health promotion.

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 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 and recorded the patient's consent clearly in the patients' records.

Staff could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards. Mandatory training for Safeguarding included training in consent, the Mental Capacity Act and Deprivation of Liberty Safeguards. The provider's Mental Health Act policy which applied to the hospital and outpatient's department was up to date and available for staff to access online.

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. 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. A review of 6 patient records showed the patient's consent was recorded correctly, including in recently implemented electronic records. Staff confirmed that no Deprivation of Liberty Safeguards were currently in place for patients attending the outpatient's department.

For other detailed findings relating to Consent, Mental Capacity Act and Deprivation of Liberty Safeguards refer to Surgery, Effective, Consent, Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Good

Outpatients

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. Patients said staff treated them well and with kindness. Responses from patients who visited the outpatient's department were consistently positive. Patient satisfaction survey results for outpatients demonstrated a very high level of patient satisfaction.

We spoke with 10 patients who were visiting the outpatient department, and each spoke very highly of the care and treatment they received in the hospital. Patients said the standard of care and delivery of care was excellent throughout. Patients commented that their visits to outpatients were very well organised and timely to fit in with their arrangements and existing commitments. Patients said staff were welcoming, knew who they were and asked how they wanted to be addressed. Patients appreciated their diagnostic tests or physiotherapy being arranged for them during their outpatient's appointment. Patients said they would recommend the hospital to other people.

Staff followed policy to keep patient care and treatment confidential. Patients we spoke with had experienced no issues with confidentiality or privacy and dignity. 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.

For other detailed findings relating to Compassionate care refer to Surgery, Caring, Compassionate care.

Emotional support

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

Patients received appropriate emotional support as part of their care and treatment. Staff gave patients and those close to them help, emotional support and advice when they needed it. Outpatients' department staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Private areas of the department could be available, and patients were supported to take time to use these areas as appropriate. Staff understood how to break bad news and demonstrated empathy in having difficult conversations with patients.

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 and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

For other detailed findings relating to Emotional support refer to Surgery, Caring, Emotional support.

Understanding and involvement of patients and those close to them.

Good

Outpatients

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

Staff talked with patients, families, and carers in a way they could understand, using communication aids where necessary. Patients spoke very positively about the way staff communicated with them. Staff made sure patients and those close to them understood their care and treatment.

Services to support translation, hearing, sight loss and accessible information to support these services were available. Patients could also request a chaperone. Staff supported patients to make informed decisions about their care.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Each patient visiting outpatients was provided with a feedback sheet and online patient satisfaction surveys for the hospital went live during 2023. Patients gave positive feedback about the service. We spoke with 10 patients who were visiting the outpatient department, and each spoke very highly of the care and treatment they received in the hospital.

For other detailed findings relating to Understanding and involvement of patients and those close to them refer to Surgery, Caring, Understanding and involvement of patients and those close to them.

Is the service responsive?

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 and coordinate care with other services and providers.

Managers planned and organised services, so they met the changing needs of the local population. The hospital worked closely with other local health service providers to provide complementary services.

Facilities and premises were appropriate for the services being delivered. The outpatient's department on the first floor and the physiotherapy department located on the second floor of the hospital were accessed by a lift or stairs. The service had suitable facilities for the use of patients and their relatives when visiting the hospital. The department had nine clinic rooms available for consultant use when seeing patients and a minor treatment room for procedures under local anaesthetic only. The hospital had a car park with accessible spaces, but availability of parking was limited. Patients were not always able to find parking adjacent to the hospital.

The provider's website had information about services and treatments available to patients with details of how to contact the hospital about these. Patients could arrange an initial appointment online or by calling the hospital. The website provided details of treatment risks and advice on costs. Managers monitored and took action to minimise missed appointments. Managers ensured that patients who did not attend appointments were contacted to rearrange their appointment and their referring organisation informed.

For other detailed findings relating to Service delivery to meet the needs of local people refer to Surgery, Responsive, Service delivery to meet the needs of local people.

Good

Outpatients

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 understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff, and patients, relatives and carers could get help from interpreters or signers when needed. Interpreter services could be made available by phone or video call. To access the outpatient's department, patients were assisted to use the lift if they required this. Medical staff we spoke with could access mental health support for patients if this was identified as a need.

The hospital revised procedures for safe discharge following minor surgery to support patients with follow-up instructions for pain management, wound care and arranging their follow-up appointments. Discharge information shared with the patient was reviewed with consultants who carried out minor surgery in the outpatient's department so that patients felt well informed of follow-up advice.

For other detailed findings relating to Meeting people's individual needs refer to Surgery, Responsive, Meeting people's individual needs.

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.

In the six months prior to our inspection, the hospital had a total of 11,604 attendances of which 8,945 were private patients and 2,659 NHS patients. Referral to treatment times showed 82.85% of patients were seen within 18 weeks overall.

Managers monitored waiting times and ensured patients could access the services they needed when required. Patients could be referred to the outpatient's department direct from their GP, from an NHS hospital, or by self-referral. Patients could arrange appointments by phone or through the hospital's website and were offered an appointment with their preferred consultant if possible.

Medical staff told us that patients were usually seen within a week or two of their referral. Consultants were allocated one hour for new patients and allowed 30 minutes for follow-up appointments. Managers worked to keep the number of cancelled appointments and treatments in the outpatient's department to a minimum. 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.

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. Patients told us that their visits to outpatients were very well organised and timely to fit in with their arrangements and existing commitments. Patients appreciated their diagnostic tests or physiotherapy being arranged for them during or following their outpatient's appointment.

For other detailed findings relating to Access and flow refer to Surgery, Responsive, Access and flow.

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 patients in the investigation of their complaint.

Patients, relatives, and carers knew how to complain or raise concerns. The outpatient's department had received a total of 11 complaints in the 6 months from May 2023 and each of these were resolved within timeframes.

Complaints were acknowledged within 2 days and a further 18days were allocated to investigate and respond to the complainant. Complaints were recorded in the risk management system and managed by a central hospital complaint team who responded to the complainant.

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. Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. Managers asked for a reflective piece of work from staff following a patient complaint to support the staff member's learning.

We requested details of the most recent resolved complaint for the outpatient's department with the outcome. We found evidence of learning was identified in the department from complaints received. A report of patient complaints and feedback was completed monthly for discussion at the clinical governance meeting. Following this meeting a governance bulletin was produced and sent to all staff.

Staff could give examples of how they used patient feedback to improve daily practice. Recent complaints about fees and prices had been identified as a theme. There were three complaints about outpatient charging discussed at the October 2023 meeting and the meeting record shows new prices were to be displayed in each room and staff were to discuss with patients that they may be charged for additional tests.

For other detailed findings relating to Learning from complaints and concerns refer to Surgery, Responsive, Learning from complaints and concerns.

Is the service well-led?

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's Outpatient department was led by a clinical services manager who reported to the director of clinical services, who in turn reported to the registered manager and director of the hospital. This provided a clear leadership structure for the department. The clinical services manager provided oversight for the daily operation of the service, supported by the hospital senior management team and directors of the Circle Healthcare Group.

Good

Outpatients

We found leaders had a ready grasp of the challenge of running the outpatient's department which was appreciated by each member of medical, nursing, and administrative staff. Leaders supported staff to maintain and develop their skills and were involved in recruitment interviews, and training and development activities with staff. Staff were coached by the senior leadership team and where appropriate encouraged to take on more senior roles.

Members of staff we spoke with commented on the improvement in leadership they had experienced following recent senior appointments. Staff in outpatients told us they received consistent support from senior managers. Staff were not afraid to approach the leadership team with their ideas for sharing good practice. Senior managers could also evidence where they had taken action to address behaviour and performance issues.

For other detailed findings relating to Leadership refer to Surgery, Well-led, Leadership.

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. 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 the vision and strategy and monitor progress.

The outpatient's department objectives for 2023-24 included clinical outcomes, engaging staff, optimal value, and positive patient experience which reflected the hospital's strategic objectives. We found outpatients staff were involved in the development and review of these strategic objectives which reflected the vision and strategy for the department. The corporate objectives were also included in staff appraisals.

Senior staff in the outpatient's department monitored their progress against the strategy with the involvement of staff and we reviewed evidence of how objectives were achieved year-to-year. Staff attended a 'time out' in February 2023 to develop the values on display in the hospital. These were reviewed in September 2023 at a further 'time out' and updated following feedback from the management team.

Progress against the strategy was included in the monthly leadership agenda and this year at a leadership away day. Teams also discuss the strategy and feedback to the senior leadership team. A member of the team told us they wrote the compassioning care part for the Circle Group which was implemented in the hospital.

For other detailed findings relating to Vision and Strategy refer to Surgery, Well-led, Vision and 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 in the outpatient department felt supported by their immediate colleagues and staff across the hospital. Staff spoke positively of the culture following transformation. Staff we spoke with described the culture as 'open' and they said they were very happy working in the department. Staff told us the Circle Health Group was an excellent company to work for.

Staff were not afraid to approach the senior team to share their thoughts. Suggestions for improvement were listened to. Staff said managers were really supportive. In the most recent year they had a better experience – the hospital was more structured and organised making it a better place to work.

B-heard survey results were positive feedback about the outpatient's department, including physiotherapy, reflecting a positive culture. Staff we spoke with mentioned the hospital's emphasis on their wellbeing. The hospital and department were committed to maintaining the health and wellbeing of its staff. A staff member told us they received an 'admin' day to support a structured training programme. New starters we spoke with had found everyone very approachable and welcoming. Expectations were clearly articulated. A staff member described having raised an issue about another member of staff in which they felt very supported.

For other detailed findings relating to Culture refer to Surgery, Well-led, Culture.

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 followed the Circle Health Group corporate governance assurance framework.

The Circle operating system (COS) aligned with the hospital's corporate values which in turn were implemented in the outpatient's department. Staff in the outpatient's department could describe how they were involved in the COS development. Outpatients staff could also describe key aspects of the COS which they used, for example SWARM in response to a safety issue.

A clinical governance committee meeting was held monthly with representatives from each department in the hospital including outpatients. Performance was discussed and included learning from incidents, patient feedback, audit results and safety alerts. Items were escalated to hospital managers in the first instance.

Outpatient team meetings were held monthly. We reviewed minutes of meetings held in September and October 2023. Information from other hospital committees was shared with the team, for example, learning from incidents. Managers ensured staff attended team meetings or had access to full notes when they could not attend.

The department was also represented at twice daily meetings which focussed on safety and staff engagement, supported by staff communications and bulletins. The outpatients team met after the hospital-wide meeting for daily planning of patient clinics. Resourcing and staffing requirements for patient specific needs were discussed at this meeting. The physiotherapy team also met after the hospital-wide meeting.

The clinical services manager for outpatients also represented the department at infection prevention and control meetings held quarterly, safeguarding meetings held twice yearly and at subgroup meetings for specific topic areas, for example, digital and pathology. Biannual meetings were also held with the local NHS acute hospital to support a service level agreement for pathology.

For other detailed findings relating to Governance refer to Surgery, Well-led, Governance.

Management of risk, issues and performance

Good

Outpatients

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.

The outpatient's department assessed and responded safely to patient risks. Staff completed risk assessments for patients during clinic appointments when required. The completion of risk assessments was not required for each patient visiting as an outpatient. A safety checklist was completed before each minor procedure which followed the World Health Organisation's surgical safety checklist. Patient records we reviewed showed appropriate risk assessments had been completed.

A member of the outpatient's department participated in a safety 'huddle' of the hospital-wide crash team twice daily where risks were reviewed and any additional risks for outpatients, for example from the minor procedures list, were considered and mitigated. Each member of the team was assigned a specific role.

An electronic risk management system was used to record risks identified in the outpatients and physiotherapy departments and the wider hospital. Key risks had a risk owner and review date. Each member of staff had access to the system for their own department and the head of department or assigned person could edit this. Outpatients staff we spoke with were able to describe the risks in the department and mitigations of the risk. No high-risk items were identified in the outpatient's department. Managers said they proactively asked staff if they thought anything else should be on the risk register. Risks were reviewed regularly and at quarterly risk review meetings attended by the clinical services manager, the director of clinical services and the executive director.

The outpatient's department monitored its performance and supported this through a programme of audit. Service performance improvement was linked to corporate objectives through clinical governance. Key performance indicators were managed, and outliers were reviewed. Staff received feedback about hospital performance through audit processes at staff meetings and through information shared on the hospital intranet.

For other detailed findings relating to Management of risk, issues and performance refer to Surgery, Well-led, Management of risk, issues and performance.

Information Management

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

The outpatient's department collected and analysed data on staffing, quality and safety. Information gathered enabled monitoring of compliance with, for example hand hygiene, use of personal protective equipment, medicines management and the surgical safety checklist.

Records were stored in hard copy and electronic form. An electronic patient appointment booking system was in use. Booking referral forms were kept in patient records. Records were stored securely. Within consultation and clinic rooms,

notes were stored in locked cabinets. Consultation rooms had a mobile storage box which was used for confidential storage of patient notes when clinics were in use. Records at reception were not accessible to patients or visitors. Electronic information was stored securely. Staff could access the information they needed to understand performance and to inform decision making.

Staff completed training in information governance training as part of mandatory training. The service had NHS digital data security and protection toolkit accreditation.

For other detailed findings relating to Information management refer to Surgery, Well-led, Information management.

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 outpatient's department collected feedback from patients which was analysed to identify trends. Members of the public were also involved in Patient Led Assessment of the Care Environment (PLACE) audits. The hospital followed up actions from its most recent PLACE audit. The hospital introduced 'patient hour' in response to friends and family responses and comments at the patient experience meeting. Patient representatives attended the monthly clinical governance meeting where patient feedback was discussed.

The Circle operating system (COS) used in the Circle Health Group focussed on engagement and empowering staff 'to work together to be safe and effective, recognising everyone has a responsibility to contribute towards this goal'. A representative of outpatients' staff attended the daily communications meeting in the hospital. Information of relevance to outpatients as well as information for staff in the rest of the hospital about the outpatient's department, was shared through staff newsletters.

The hospital engaged with staff through an annual b-Heard survey, which was a national indicator for the Circle Health Group and through a number of other mechanisms. The b-Heard survey results were reported at hospital level, rather than department level. However, outpatient's department staff reviewed the results and were in process of developing an improvement plan. Outpatients staff told us because they were a small team information could be shared with them daily by managers. Managers engaged well with them and recognised their contributions.

For other detailed findings relating to Engagement refer to Surgery, Well-led, Engagement.

Learning, continuous improvement and innovation

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

The outpatient's department used information to improve care and staff were committed to continuous improvement. The service recognised staff for innovations and quality improvements. Assessment of efficiency changes was undertaken as for a risk assessment to ensure care and safety were not compromised. Staff told us suggestions for improvement were listened to. Managers told us new innovations were accepted by the team.

Good

Outpatients

The Circle Health Group applied the Circle Operating System (COS) methodology to support staff working together safely and effectively, recognising each member of staff's responsibility to contribute towards this goal. The outpatient's department shared examples of its contribution to this, for example in physiotherapy, joint post-operative knee classes, and investment in strength training equipment to support the patient's post-operative rehabilitation. The hospital also developed a standard operating policy for outpatient minor procedures to support safety, resulting in an upgrade to the treatment room to extend the procedures undertaken.

The hospital shared examples of recent innovations in delivery of services in the outpatient's department. Two examples shared with us were enhancing clinical staff's knowledge of wound care within the department to support high standards of clinical care being delivered through the outpatient's department; and increasing the number of general practitioner clinics to support the hospital's business strategy. The physiotherapy service was being promoted outside of hospital only services which had increased the number of people attending physiotherapy only services from the local community.

Good

Diagnostic and screening services

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

Is the service safe?

Good

Mandatory training

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

Staff kept up to date with their mandatory training. Mandatory training completion for the hospital in 2022-23 was 100%. Staff had time to complete mandatory training. For new starters, a 3-month window was allowed. Radiology department training was 94.3% completed at inspection. Ultrasound department training was completed. All staff completed specific radiation protection training and radiographers had received specific training in medicines management and aseptic non-touch technique at induction.

Mandatory training was comprehensive and met the needs of patients and staff. Staff in the radiology department completed mandatory training on subjects to support them in their roles including infection prevention and control, fire safety, mental health, learning disability, dementia autism awareness and conflict resolution. Advanced, intermediate, and basic life support (depending on role) aseptic non-touch technique, equality and diversity and information governance were included in mandatory training. Staff explained how their training was helpful in preparing them for their roles.

For other detailed findings relating to Mandatory training refer to Surgery, Safe, Mandatory 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.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

The hospital confirmed that training for diagnostic imaging staff in the Mental Capacity Act and

Good

Diagnostic and screening services

The hospital confirmed that no safeguarding incidents were raised within Diagnostic imaging during the period May 2023 to October 2023. Current safeguarding policies for the provider were available on-line and accessible to staff.

For other detailed findings relating to Safeguarding refer to Surgery, Safe, Safeguarding.

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.

During refurbishment of the imaging department, diagnostic services had been relocated within the hospital to Ambulatory Care Rooms 1 and 2 and formed part of the ward cleaning schedule during the refurbishment period. All areas in use for diagnostic imaging were visibly clean and furnishings were well maintained. A daily cleaning schedule was up to date for November 2023 and demonstrated all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment. Staff received training in infection prevention and control. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. The hospital monitored its effectiveness in reducing the risk of spreading infections.

Staff disposed of clinical waste safely. The diagnostic department followed decontamination guidance. Rooms in temporary use for diagnostics imaging were provided with clinical waste, general waste and sharps bins. Sharps bins were labelled and in date. Staff cleaned equipment after patient use and equipment was labelled to show when it was last cleaned.

The service completed infection prevention and control audits regularly to monitor staff compliance with personal protective equipment use compliance with local rules, sharps storage and disposal. The diagnostics imaging department achieved a high level of compliance in audits.

For other detailed findings relating to cleanliness, infection control and hygiene refer to Surgery, Safe, cleanliness, infection control and hygiene.

Environment and equipment

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

The diagnostic imaging department had suitable facilities for the use of patients and their relatives when visiting the hospital. At inspection we found diagnostics imaging had been relocated to a temporary room for a period of 8 weeks whilst building work and refurbishment were in progress. The department had access to the latest technology and equipment including diagnostic imaging x-ray and ultrasound. We inspected the temporary facilities and reviewed the building work in progress in the new imaging suite due for completion in November 2023.

Where items of equipment had maintenance services scheduled which fell during the 8 weeks of refurbishment, the maintaining and servicing had been rearranged to avoid the refurbishment where safe to do so. Some manufacturers had loaned items of equipment to the hospital whilst the diagnostic imaging room was unavailable, and this equipment was included in the inspection. Staff carried out daily safety checks of specialist equipment.

Discrepancies were discussed at imaging department reviews (DPRs) and clinical governance committee meetings, with escalation and actions taken as required. Radiographers did not use home reporting services due to the standard of information technology signal required for accuracy.

For other detailed findings relating to Environment and equipment refer to Surgery, Safe, Environment and equipment.

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 department assessed and responded safely to patient risks. Monthly departmental workplace inspections of radiology were undertaken. We reviewed the most risk assessment undertaken for the X-ray department and saw that mitigations were in place for the temporary facilities. A member of the diagnostics team participated in a safety 'huddle' of the hospital-wide crash team twice daily where risks were reviewed and any additional risks for the diagnostics service identified and mitigated. Each member of the team was assigned a specific role.

Staff responded promptly to any sudden deterioration in a patient's health. Although acutely unwell patients rarely attended the diagnostic imaging department, staff were trained appropriately to respond. Resuscitation scenarios were completed every three months. Emergency resuscitation trolleys were conveniently located in easy reach of all areas of the department. Resuscitation equipment was checked daily, and these checks were recorded.

We reviewed evidence of World Health Organisation pause and check audits undertaken for diagnostic imaging for the most recent 12 months. Results showed 100% compliance. The department had an established process to ensure the correct patient was receiving the appropriate scan. Staff addressed any specific risk issues and undertook a 'pause and check' checklist with each patient to confirm the patient's name, address, and body part for the scan. This followed the requirements of Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R), to prevent radiation exposure to the wrong patient. We observed staff using the 'pause and check' process.

The department had a pregnancy check protocol in place. 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. We observed pregnancy check notices displayed to prompt patients who may be pregnant to inform staff before exposure to radiation.

External physics support with a named radiation protection supervisor was in place and a named radiation protection advisor to access for advice. Staff were aware of who these individuals were. The external advisors were involved in commissioning the new facilities and visited the hospital in November 2023. We found dose reference levels were available for the temporary room and warning signs were displayed. The department monitored the level of occupation exposure of radiation to staff. We observed information about 'Understanding Radiation: Risk vs Benefit' on display in the waiting room.

Audits to support imaging accuracy followed Circle Group corporate policy for radiology reporting discrepancies, near-misses and adverse events. Audits followed the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R). No concerns were identified from audit. Local rules and employer's procedures (IR(ME)R) which protect staff and patients from ionising radiation were in place and we saw evidence of them having been read by staff. The local rules had been amended in September 2023 to include reference to the temporary X-ray room configuration. Staff we spoke with understood the application of the local rules.

Good

Diagnostic and screening services

For other detailed findings relating to Assessing and responding to patient risk refer to Surgery, Safe, Assessing and responding to patient risk.

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, agency, and locum staff a full induction.

The diagnostics imaging department had enough specialist and support staff to keep patients safe. Managers adjusted staffing levels daily according to the needs of patients. Managers calculated and reviewed the number and grade of staff needed for each shift in accordance with national guidance.

The service had two radiographers, one sonographer and three imaging assistants. Staffing for the department was discussed during at the daily hospital meeting to ensure staffing levels were safe. To cover sickness and other contingencies, four bank staff were available and the hospital could call on a neighbouring Circle Group Hospital for staff, for example, to cover weekends. The department was carrying one vacancy. We found five radiologists who worked in conjunction with local hospitals visited the department on most days. We reviewed the staff rotas for the diagnostic imaging department for the most recent three months which confirmed these arrangements.

A Circle Health Group mobile magnetic resonance imaging (MRI) vehicle visited the hospital site for two days per week. The inspection did not include a review of this service.

For other detailed findings relating to staffing refer to Surgery, Safe, Nurse staffing and Surgery, Safe, Medical staffing.

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 for the diagnostic imaging department were complete, and relevant staff could access them. We reviewed the imaging referral form verification check process which provided a framework for patient record checks and reviewed the records for 7 patients. Information included medical history, consent, risk assessments, for example allergies, treatment plans, and medicines.

A current data protection policy was in place which included diagnostic imaging records and met the requirements of data protection legislation including the Data Protection Act (2018) and the General Data Protection Regulations (2016).

Records were stored in hard copy and electronic form. Booking referral forms were kept in patient records. Diagnostic imaging records were stored and accessed on an electronic system. Records were stored securely with notes stored in locked cabinets. Records at reception were not accessible to patients or visitors.

For other detailed findings relating to Records refer to Surgery, Safe, Records.

Medicines

Good

Diagnostic and screening services

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

Staff followed current national practice to check patients had the correct medicines. Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. The department did not keep controlled drugs.

Staff completed medicines management as part of their mandatory training to administer contrast medicines and staff were up to date with this training. The service administered contrast medicines for specific scans. Contrast medicines used were recorded in patient notes. The Medicines were stored securely. Temperature checks were completed and monitored for refrigerated medicines.

Staff completed medicines records accurately and kept them up to date. Staff completed medicines management audits for the department. Medicine audit records for the most recent six months showed 100% compliance.

For other detailed findings relating to Medicines refer to Surgery, Safe, 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 raised concerns and reported incidents and near misses in line with the service's policy. The diagnostics imaging department had reported 6 incidents in the six months since June 2023. The department had nothing to report to IR(ME)R in the last 12 months. No never events had occurred in the previous 12 months.

For other detailed findings relating to Incidents refer to Surgery, Safe, Incidents.

Is the service effective?

Inspected but not rated

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 reviewed the hospital's policies related to care of people visiting diagnostic imaging which included safeguarding vulnerable adults, complaints, mental capacity, deprivation of liberty and restrictive practice. These policies were up to date and reflected national guidance from National Institute for Health and Care Excellence, the Nursing and Midwifery Council, the Office of the Public Guardian and more general guidance applicable to NHS patients.

Good

Diagnostic and screening services

For other detailed findings relating to Evidence-based care and treatment refer to Surgery, Effective, Evidence-based care and treatment.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink. Including those with specialist nutrition and hydration needs. Patients we spoke with confirmed that where relevant food and drink of their choice had been offered to them during their visit to the department.

For other detailed findings relating to Nutrition and hydration refer to Surgery, Effective, Nutrition and hydration.

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. Our review of patient records confirmed that staff monitored patient's pain levels during their visit to the hospital where this was relevant to the patient's treatment.

Staff in the diagnostic imaging department did not normally administer pain relief as patients were visiting the department for only a short period of time.

For other detailed findings relating to Pain relief refer to Surgery, Effective, Pain relief.

Patient outcomes

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

Outcomes for patients were positive, consistent, and met expectations. The patient satisfaction survey results for October 2023 reflected very positive patient comments with shows a high proportion of patients' experience being very satisfied. Patient's expectations were being met or exceeded.

The hospital told us it did not have a performance dashboard for diagnostic imaging for the previous 12 months as the number of incidents were not reported separately. The hospital shared its audit of radiation doses to patients to provide evidence of doses being kept as low as reasonably practicable. Compliance with clinical performance for radiation protection in the previous 12 months was consistently100%.

Good

Diagnostic and screening services

The hospital presents diagnostic imaging incidents for the previous 12 months as these are recorded on the incident management system and reported to 3 internal governance meetings and discussed at the Corporate Clinical Governance Committee chaired by the Group Clinical Director. The imaging lead is a member of this committee so that themes or trends within imaging incidents are identified.

The diagnostic imaging department operated to a five-day turnaround and a waiting report was prepared weekly and shared with an external reporting provider.

For national benchmarking comparators of the diagnostic imaging service, the hospital reported the results of its monthly audit working group which enabled each Circle Group hospital to share learning. Audits for diagnostic imaging compared with other sites of similar size and service showed the service performed very well against five key measures of clinical practice. We reviewed the minutes of the imaging department monthly meeting which showed learning and outcomes from clinical audit reports were reported and staff completed an action plan where required.

For other detailed findings relating to patient outcomes refer to Surgery, Effective, Patient outcomes.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff 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. We reviewed evidence for diagnostics imaging staff that managers gave each member of staff a full induction tailored to their role before they started work. Skills and competencies booklets were provided for staff to complete over a three-month period.

We reviewed the local policy assistant practitioner scope of practice document which identified named staff in the diagnostic imaging department entitled to act as referrer or practitioner or operator within a specified scope of practice. The policy was due for renewal in July 2024.

Managers supported staff to develop through yearly, constructive appraisals of their work. We reviewed evidence that appraisals were up to date for each member of diagnostic imaging staff.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge, including being allocated dedicated time for training. Managers made sure staff received any specialist training for their role. The Circle Health Group provided funding to support specific training needs. We reviewed the referral list and criteria for non-medical practitioners and saw evidence that Ionising Radiation (Medical Exposure) Regulations training for six members of staff was in date.

For other detailed findings relating to Competent staff refer to Surgery, Effective, Competent staff.

Multidisciplinary working

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

Good

Diagnostic and screening services

Staff held regular multidisciplinary meetings to discuss patients and improve their care. A daily meeting in the hospital was attended by a representative from each hospital department including diagnostic imaging. Each department familiarised with other staff including agency staff who were on duty that day in the hospital.

Patients could see more than one clinician involved in their care and treatment during their visit to the hospital. Where possible the hospital would arrange for the patient's diagnostic tests to coincide with their next appointment. The hospital also shared examples of how multidisciplinary working with the local NHS hospital, community-based services and ambulance services had benefited patients.

A service agreement was in place with the local NHS hospital for the transfer of patients, for example, for CT scanning where a patient had experienced an unwitnessed fall, and a member of staff may accompany the patient if their condition warranted.

For other detailed findings relating to Multidisciplinary working refer to Surgery, Effective, Multidisciplinary working.

Seven-day services

Key services were available to support the delivery of timely patient care.

The diagnostic imaging department opened Monday to Friday 8am to 5pm with some opening on Saturdays and Sundays 10am to 12am which we were informed was on an as required basis. Members of staff including bank staff were also on call 24 hours on a rota basis for urgent scan requests. The department did not provide an urgent and emergency service which may require seven days a week operation.

For other detailed findings relating to Seven-day services refer to Surgery, Effective, Seven-day services.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas. Staff assessed the patient's health at each appointment and provided for individual needs to support a healthier lifestyle.

In reviewing patient records and in speaking with patients we found that topics to support health promotion and health education needs were reviewed and discussed along with care and treatment. Staff gave patients practical support and advice about safety of diagnostic scans.

The hospital displayed relevant information promoting healthy lifestyles and support available in areas accessible to patients. The provider's website contained information explaining the relevance of treatment options including explanations of benefits to patients.

For other detailed findings relating to Health promotion refer to Surgery, Effective, Health promotion.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Good

Diagnostic and screening services

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 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 and recorded the patient's consent clearly in the patients' records.

Staff could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards. Mandatory training for Safeguarding included training in consent, the Mental Capacity Act and Deprivation of Liberty Safeguards. The provider's Mental Health Act policy which applied to the hospital and diagnostic imaging department was up to date and available for staff to access online.

Deprivation of Liberty Safeguards was including in safeguarding training and we saw evidence the overall completion rate was 91.7% for the diagnostic imaging department.

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. 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 gained consent before undertaking a scanning procedure and this was recorded. We reviewed a sample of five completed consent forms of patients attending the diagnostic imaging department for scans and procedures conducted in the two weeks prior to our inspection. The patient's consent was recorded correctly. Staff confirmed that no Deprivation of Liberty Safeguards were currently in place for patients attending the department.

For other detailed findings relating to Consent, Mental Capacity Act and Deprivation of Liberty Safeguards refer to Surgery, Effective, Consent, Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

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. Patients said staff treated them well and with kindness. Responses from patients who visited the diagnostic imaging department were consistently positive. Patient satisfaction survey results demonstrated a high level of patient satisfaction.

We spoke with patients who were visiting the diagnostic imaging department and received consistently very positive feedback about the care and treatment they received. Patients said they found the standard of care and delivery of care

reassuring. They had been told what to expect and had been put at ease by everyone. Patients had been given treatment options and asked what appointment times were convenient for them. Patients appreciated their diagnostic tests being arranged for them during their outpatient's appointment. Staff were friendly and the patients said they wouldn't change anything. A first-time user of the service said they had no issues at all.

We reviewed a selection of patient satisfaction survey results for the diagnostic imaging department for the most recent six months. Amongst the comments was " Everything ran like clockwork from admission to discharge. All members of staff were welcoming, kind, professional, helpful and efficient. I can't thank them all enough; I felt totally safe and so cared for by all members of staff in each department throughout my patient journey." Consistent themes in survey feedback included caring, courteous, friendly, and professional staff.

Feedback of patient experience scored 4.7 out of 5 in Google reviews. Friends and family test results including diagnostic imaging was 93.5% or above during the previous 12 months.

We reviewed a selection of examples demonstrating the consistency of this feedback from the most recent 6 months. Free text patient survey comments consistently referenced excellence in the care provided. Comments about the care in the previous six months included "As an NHS referral I could not have asked to be seen anywhere better"; "Nothing to be improved", "Excellent service and experience", "Can think of nothing that could have been done better" and "My experience could not have been better." A member of staff who had recently joined the department commented that they were very impressed with the standard of patient care.

Staff followed policy to keep patient care and treatment confidential. Patients we spoke with had experienced no issues with confidentiality or privacy and dignity. 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.

For other detailed findings relating to Compassionate care refer to Surgery, Caring, Compassionate care.

Emotional support

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

Patients received appropriate emotional support as part of their care and treatment. Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Private areas of the department could be available, and patients were supported to take time to use these areas as appropriate. Staff understood how to break bad news and demonstrated empathy in having difficult conversations with patients.

Patient leaflets entitled "Taking a detailed look at you" providing information in question-and-answer format were available for magnetic resonance imaging scan, ultrasound, and x-ray examination. Interpretation and translation services provided information for patients in a number of formats.

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 and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs.

For other detailed findings relating to Emotional support refer to Surgery, Caring, Emotional support.

Good

Diagnostic and screening services

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 talked with patients, families, and carers in a way they could understand, using communication aids where necessary. Patients spoke very positively about the way staff communicated with them. Staff made sure patients and those close to them understood their care and treatment.

Services to support translation, hearing, sight loss and accessible information to support these services were available. Patients could also request a chaperone. Staff supported patients to make informed decisions about their care.

We reviewed examples of accessible information leaflets for patients including hearing, sight, and for translation services, emotional support If you need an interpreter. Chaperones were available for consultations examinations or procedures.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Each patient visiting diagnostic imaging was provided with a feedback sheet and online patient satisfaction surveys for the hospital went live during 2023. Patients gave positive feedback about the service. We spoke with patients who were visiting the diagnostic imaging department, and each spoke very highly of the care and treatment they received in the hospital. Satisfaction with the imaging department is positive, with the only theme in terms of feedback in the most recent six months being the service provided by the administration team for a short period during refurbishment.

For other detailed findings relating to Understanding and involvement of patients and those close to them refer to Surgery, Caring, Understanding and involvement of patients and those close to them.

Is the service responsive?

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. The hospital managing and organised imaging appointments based on patient and referring clinician demand. The hospital worked closely with other local health service providers to provide complementary services. In the 12 months prior to inspection, the diagnostic testing and screen service undertook 855 MRI 855 scans, 517 Ultrasound tests and 3278 diagnostic imaging tests.

Facilities and premises were appropriate for the services being delivered. The diagnostic imaging department was accessible from the ground floor lift or stairs. The service had suitable facilities for the use of patients and their relatives when visiting the hospital. The hospital had a car park with accessible spaces, but availability of parking was limited. Patients were not always able to find parking adjacent to the hospital.

Good

Diagnostic and screening services

The provider's website had information about services and treatments available to patients with details of how to contact the hospital about these. The website provided details of treatment risks and advice on costs. Managers monitored and took action to minimise missed appointments. Managers ensured that patients who did not attend appointments were contacted to rearrange their appointment and their referring organisation informed.

For other detailed findings relating to service delivery to meet the needs of local people refer to Surgery, Responsive, Service delivery to meet the needs of local people.

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.

A protocol was in in place for patients who did not attend for their diagnostic test to ensure the patient's individual needs and preferences were met. For the 12 months prior to our inspection, patients did not attend 53 MRI tests, 74 diagnostic imaging tests and 19 diagnostic tests. Wherever possible the test was arranged whilst the patient was visiting the hospital.

For other detailed findings relating to Meeting people's individual needs refer to Surgery, Responsive, Meeting people's individual needs.

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.

The service monitored waiting times and ensured patients accessed services when needed and received treatment within agreed timeframes and a service agreement was in place with the local NHS hospital to process scans. The hospital told us it did not have a national reporting standard but set an internal reporting standard of 90% of patient images for plain film and MRI scans being reported within five days.

If the report was not completed to this timeframe it was escalated for immediate action. We found the service did not have long wait lists within the imaging department - all modalities were seen within the month referred, unless though patient choice for a more convenient date.

For other detailed findings relating to Access and flow refer to Surgery, Responsive, Access and flow.

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.

Patients, relatives, and carers knew how to complain or raise concerns. The diagnostic imaging department had received a total of 7 complaints in the 12 months prior to our inspection.

Good

Diagnostic and screening services

Complaints were acknowledged within seven days and a further two weeks was allocated to investigate and respond to the complainant. Complaints were recorded in the risk management system and managed by a central hospital complaint team who responded to the complainant. We reviewed two resolved complaints for the department which showed evidenced of learning was embedded following the resolution of complaints.

Complaints were monitored through the incident management system which allowed for feedback to be registered and monitored by each department with the Senior Management Team. Updates on progress are given at the daily communication meeting. A weekly meeting to discuss complaints has been established to ensure investigations and responses are given to the patient within the timescales of the complaints policy and lessons learnt are communicated to departments through a monthly governance bulletin.

For other detailed findings relating to Learning from complaints and concerns refer to Surgery, Responsive, Learning from complaints and concerns.

Is the service well-led?

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's diagnostic imaging department was led by a clinical services manager who reported to the director of clinical services, who in turn reported to the registered manager and director of the hospital. This provided a clear leadership structure for the department. The clinical services manager provided oversight for the daily operation of the service, supported by the hospital senior management team and directors of the Circle Healthcare Group.

We found leaders had a ready grasp of the challenge of running the diagnostic imaging department which was appreciated by each member of medical, nursing and administrative staff.

Leaders supported staff to maintain and develop their skills and were involved in recruitment interviews, and training and development activities with staff. Staff were coached by the senior leadership team and where appropriate encouraged to take on more senior roles.

Members of staff we spoke with commented on the improvement in leadership they had experienced following recent senior appointments. Staff in diagnostic imaging told us they received consistent support from senior managers. Staff were not afraid to approach the leadership team with their ideas for sharing good practice. One example cited was to increase the utilisation of radiology services, where possible by x-ray of post operative patients on the same day of surgery. This limited any delay in the patient discharge, ensured the images had been reviewed prior to discharge, and enabled better planning of staffing in the department.

Senior managers could also evidence where they had taken action to address behaviour and performance issues.

For other detailed findings relating to Leadership refer to Surgery, Well-led, Leadership.

Good

Diagnostic and screening services

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. 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 diagnostic imaging department objectives for 2023-24 included clinical outcomes, staff engagement, optimal value and positive patient experience which reflected the hospital's strategic objectives. We found diagnostic imaging staff were involved in the development and review of these strategic objectives which reflected the vision and strategy for the department. The corporate objectives were also included in staff appraisals.

Senior staff in the diagnostic imaging department monitored their progress against the strategy with the involvement of staff and we reviewed evidence of how objectives were achieved year-to-year. Staff attended a 'time out' in February 2023 to develop the values on display in the hospital. These were reviewed in September 2023 at a further 'time out' and updated following feedback from the management team.

Progress against the strategy was included in the monthly leadership agenda and this year at a leadership away day. Teams also discuss the strategy and feedback to the senior leadership team. A member of the team told us they wrote the compassioning care part for the Circle Group which was implemented in the hospital.

For other detailed findings relating to Vision and Strategy refer to Surgery, Well-led, Vision and 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 in the diagnostics imaging department felt supported by their immediate colleagues and staff across the hospital. Staff spoke positively of the culture following transformation. Staff we spoke with described the culture as 'open' and they said they were very happy working in the department. Staff told us the Circle Health Group was an excellent company to work for.

Staff were not afraid to approach the senior team to share their thoughts. Suggestions for improvement were listened to. Staff said managers were really supportive. In the most recent year they had a better experience – the hospital was more structured and organised making it a better place to work.

B-heard survey results were positive feedback about the diagnostic imaging department reflecting a positive culture. Staff we spoke with mentioned the hospital's emphasis on their wellbeing and the positive training experience. The hospital and department were committed to maintaining the health and wellbeing of its staff. A staff member told us they received an 'admin' day to support a structured training programme. New starters we spoke with had found everyone very approachable and welcoming. Expectations were clearly articulated. A staff member described having raised an issue about another member of staff in which they felt very supported.

For other detailed findings relating to Culture refer to Surgery, Well-led, Culture.

Good

Diagnostic and screening services

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 followed the Circle Health Group corporate governance assurance framework. The framework provided the structure for the hospital's governance arrangements including the hospital diagnostic imaging department to the Circle Health Group board. A consultant working under practicing privileges in the diagnostic imaging department represented the department at the quarterly medical advisory committee.

The Circle operating system (COS) aligned with the hospital's corporate values which in turn were implemented in the diagnostic imaging department. Staff in the diagnostic imaging department could describe how they were involved in the COS development. Staff could also describe key aspects of the COS which they used, for example SWARM in response to a safety issue.

A clinical governance committee meeting was held monthly with representatives from each department in the hospital including diagnostic imaging. Performance was discussed and included learning from incidents, patient feedback, audit results and safety alerts. Items were escalated to hospital managers in the first instance.

Diagnostic imaging (radiology) team meetings were held monthly. We reviewed minutes of meetings held in September and October 2023. Information from other hospital committees was shared with the team, for example, patient experience, health, and safety. Managers ensured staff attended team meetings or had access to full notes when they could not attend.

The department was also represented at twice daily meetings which focussed on safety and staff engagement, supported by staff communications and bulletins. The diagnostic imaging team met after the hospital-wide meeting for daily planning of patient clinics. Resourcing and staffing requirements for patient specific needs were discussed at this meeting.

The department confirmed no incidences of discrepancies were raised in the 12 months prior to our inspection. The department maintained an ongoing record file to document any discrepancies, which followed the discrepancy policy. The Royal College of Radiologists had recommended discrepancy meetings, and the department was considering formalising these linked to clinical supervision in the hospital.

The clinical services manager and other diagnostic imaging staff attended the annual radiation protection committee meeting most recently in July 2023. The clinical services manager also represented the department at infection prevention and control meetings held quarterly, safeguarding meetings held twice yearly and at subgroup meetings for specific topic areas, for example, digital and pathology. Biannual meetings were also held with the local NHS acute hospital to support a service agreement for pathology.

For other detailed findings relating to Governance refer to Surgery, Well-led, Governance.

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.

Good

Diagnostic and screening services

The diagnostics imaging department assessed and responded safely to patient risks. Staff completed risk assessments for patients during clinic appointments when required. Patient records we reviewed showed appropriate risk assessments had been completed.

A member of the diagnostics imaging department participated in a safety 'huddle' of the hospital-wide crash team twice daily where risks were reviewed and any additional risks for diagnostics imaging were considered and mitigated. Each member of the team was assigned a specific role.

The department had in place comprehensive assurance systems for monitoring 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 in place to drive improvement. We found significant findings work instructions were in date. The level of IRMER compliance from audit in November 2023 was very good with most aspects being fully compliant or partially compliant.

An electronic risk management system was used to record risks identified in the diagnostics imaging department and the wider hospital. Key risks had a risk owner and review date. Each member of staff had access to the system for their own department and the head of department or assigned person could edit this. Diagnostics imaging staff we spoke with were able to describe the risks in the department and mitigations of the risk. Managers said they proactively asked staff if they thought anything else should be on the risk register. Risks were reviewed regularly and at quarterly risk review meetings attended by the clinical services manager, the director of clinical services and the executive director.

The departmental risk register review included the temporary accommodation of the radiology dept and covered potentially poor patient experience due to inconsistency of MRI van access. Information governance remains on the hospital risk register and all staff are mandated to undertake workshop training.

The diagnostics imaging department monitored its performance and supported this through a programme of audit. Service performance improvement was linked to corporate objectives through clinical governance. Key performance indicators were managed and outliers were reviewed. Staff received feedback about hospital performance through audit processes at staff meetings and through information shared on the hospital intranet.

For other detailed findings relating to Management of risk, issues and performance refer to Surgery, Well-led, Management of risk, issues and performance.

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 diagnostics imaging department collected and analysed data on staffing, quality and safety. Information gathered enabled monitoring of compliance with, for example hand hygiene, use of personal protective equipment and medicines management.

Records were stored in hard copy and electronic form. An electronic patient appointment booking system was in use. Booking referral forms were kept in patient records. Records were stored securely.

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. Authorised staff had access to electronic patient records, which was restricted to individuals by their own login and passwords. Staff had completed information governance mandatory training.

The hospital was audited by an external company to monitor compliance with information security management standards. The hospital had an information security officer who was due to retire shortly after our inspection. The service had NHS digital data security and protection toolkit accreditation. The hospital regularly shared the results of performance audits with the local clinical commissioning group, for example six week wait data.

The service had data notifications arrangements in place to ensure data was consistently submitted to external organisations as required such as the Care Quality Commission.

For other detailed findings relating to Information management refer to Surgery, and outpatients Well-led, Information management.

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 diagnostics imaging department collected feedback from patients which was analysed to identify trends. Members of the public were also involved in Patient Led Assessment of the Care Environment (PLACE) audits. The hospital followed up actions from its most recent PLACE audit.

The Circle operating system (COS) used in the Circle Health Group focussed on engagement and empowering staff 'to work together to be safe and effective, recognising everyone has a responsibility to contribute towards this goal'. A representative of radiology staff attended the daily communications meeting in the hospital. Information of relevance to diagnostic imaging as well as information for staff in the rest of the hospital about the radiology department, was shared through staff newsletters.

The hospital engaged with staff through an annual b-Heard survey, which was a national indicator for the Circle Health Group and through a number of other mechanisms. The b-Heard survey results were reported at hospital level, rather than department level.

The diagnostic imaging team shared examples of development activities and shared departmental training which had taken place in the 12 months prior to our inspection. The hospital had developed its objectives through team time-out days and team meetings to build improvements in staff engagement which included the diagnostic imaging team. Some team building activities had been held to support local and corporate charities.

For other detailed findings relating to Engagement refer to Surgery, and outpatients Well-led, Engagement.

Learning, continuous improvement and innovation

Good

Diagnostic and screening services

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

The diagnostics imaging department used information to improve care and staff were committed to continuous improvement. The service recognised staff for innovations and quality improvements. Assessment of efficiency changes was undertaken as for a risk assessment to ensure care and safety were not compromised. Staff told us suggestions for improvement were listened to. Managers told us new innovations were accepted by the team.

The Circle Health Group applied the Circle Operating System (COS) methodology to support staff working together safely and effectively, recognising each member of staff's responsibility to contribute towards this goal. The hospital shared examples of recent innovations in delivery of services in the diagnostics imaging department.

For example, the doctor care access (DCA) programme involves patients seeing a GP through their insurance company, which can then refer and book the patient directly for an MRI scan. This offers patients more flexibility when choosing where and when they have their scan and speeds up the reporting process. For radiology, to increase utilisation of services, the department aims to x-ray post-operative patients on the same day of surgery. This limited any delay in the patient discharge, ensures the images have been reviewed prior to discharge, and supported planning of staffing in the department.