HCA International Limited

The Lister Hospital

Inspection report

Chelsea Bridge Road
London
SW1W 8RH
Tel: 02077307733
www.thelisterhospital.com

Date of inspection visit: 22 November 2023
Date of publication: 13/03/2024

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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Good ●
Are services well-led?	Outstanding ☆

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as outstanding because:

- The service had enough staff to care for patients and keep them safe. They had training in key skills, understood how to protect patients from abuse, and managed safety well. The service managed infection risks well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. They gave patients enough to eat and drink and gave them pain relief when needed. Managers monitored the effectiveness of the service and made sure staff were skilled and experienced. Staff worked well together for the benefit of patients and supported them to make decisions about their care. Patients had access to good information and key services were available seven days a week.
- Staff treated patients with exceptional compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff empowered and provided strong emotional support to patients, families, and carers to minimise their distress. Staff were fully committed to supporting patients, families, and carers to understand their condition and empower decisions about their care and treatment. People thought that staff went the extra mile and said care and support exceeded their expectations.
- The service actively sought to provide the care pathways needed for the patients they served. Staff went above and beyond to make reasonable adjustments to help patients access their services. People could access the service when they needed it and did not have to wait for treatment. Patients did not have to wait to be seen and surgeries could even be booked for the same day if patients felt this was what they needed. The service had a very low number of complaints, and these were very well managed.
- There was an embedded system of leadership development and succession planning. Staff felt respected and valued and were focused on providing patient centred care. The service had an open culture where patients, their families and staff could raise concerns without fear. Leaders operated excellent governance processes, and demonstrated commitment to best practice, performance and risk management systems and processes. They identified and escalated relevant risks and issues and identified actions to reduce their impact effectively and in a timely manner. All staff were committed to continually learning and improving services. Staff were actively participating in research and improvement projects.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Critical care	Not inspected	
Services for children & young people	Not inspected	
Diagnostic imaging	Good	Our rating of this service remained the same. We rated it as good because: • The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. • Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and had access to good information. Key services were available to suit patients' needs. • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. • The service planned care to meet the needs of 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

Summary of findings

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.

Medical care (Including older people's care)

Outstanding ☆

We rated this service as outstanding overall because we rated caring and well led as outstanding. We rated safe, effective, and responsive as good.

Our rating of this service improved. We rated it as outstanding because:

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

Summary of findings

- 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.
- The leadership and governance systems were used to drive and improve the delivery of high-quality person-centred care. Governance processes were embedded, and leaders demonstrated a commitment to high quality performance, risk management and best practice. There was a vision for what the service wanted to achieve and a strategy to turn it into action, these were aligned with corporate strategies and priorities. There was an embedded system of leadership development and succession planning. Staff felt respected and valued and were focused on providing patient centred care. They were recognised for their achievements. The service had an open culture where patients, their families and staff could raise concerns without fear. There was a range of patient engagement processes that included a patient forum, survey and daily engagement with senior staff to ensure patients needs were met and action taken to ensure a high-quality experience of the service. Staff were committed to continually learning and improving services. Leaders encouraged innovation and staff actively participated in improvement projects.

Outpatients

Good

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

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks

Summary of findings

to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.

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Surgery **Outstanding** ☆

We rated this service as outstanding overall because we rated caring, responsive and well led as outstanding. We rated safe and effective as good.

- The service had enough staff to care for patients and keep them safe. They had training in key skills, understood how to protect patients from abuse, and managed safety well. The service

Summary of findings

managed infection risks well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.

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Summary of findings

performance and risk management systems and processes. They identified and escalated relevant risks and issues and identified actions to reduce their impact effectively and in a timely manner. All staff were committed to continually learning and improving services. Staff were actively participating in research and improvement projects.

Urgent and emergency services

Good

We have not previously inspected urgent care. We rated it as good because:

- The service was led by a core team of skilled staff who demonstrated a significant commitment to professional development and clinical competencies. Staff levels were consistent, and the team was stable, with very little turnover or unplanned absence.
- Care was demonstrably evidence-based, and the team had developed a range of audit and benchmarking tools to drive continuous improvement. Peer review, a research-enabling culture, and support from senior medical staff contributed to a culture of effective practices.
- Multidisciplinary working was embedded in the service and was supported by remote radiology services and an extensive laboratory service, along with care pathways to private and NHS specialists. There was a strong focus on improving care for patients experiencing a mental health problem.
- Feedback from patients was consistently good with no complaints or persistent areas for improvement.
- The service planned and developed care to meet demand. They used resources to support good standards of access, such as interpretation services and tools to support communication with patients living with cognitive challenges or learning disabilities.
- Staff engaged with colleagues across the organisation and regional health economy and were proactive in using patient engagement to improve standards of care and outcomes.
- Staff felt respected, recognised, and valued and were driven to explore new ways of working and test changes to existing policies and practices.

However:

Summary of findings

- The different patient record systems meant changes to initial clinical information were not always clearly updated. This presented a risk to patients.
- While the department managed ligature risk in line with national standards, staff had limited awareness of the provider's policies.

Urgent care is a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.

Summary of findings

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Summary of this inspection

Background to The Lister Hospital

The Lister Hospital is owned and operated by HCA International Ltd. The hospital opened in 1985 and has been part of HCA healthcare since 2000. It is a private hospital in Chelsea, London.

The Lister Hospital provides day surgery, inpatient care, medical care, critical care, and, outpatients and diagnostic imaging for adults over the age of 18 years old requiring treatment and care for a variety of surgical procedures and medical conditions. Surgical services are consultant-led and include orthopaedic, gynaecological and general surgery. Medical services are a small proportion of hospital activity Services are consultant-led and include an endoscopy service. Wards provide 24-hour, 7 day a week care.

The urgent care centre (UCC) is a GP-led service that provides care to self-paying or insured patients. It provides urgent, non-emergency care on a walk-in basis for minor injuries and illnesses, including plaster casting for broken bones, diagnostic point of care testing and a range of other treatments. The UCC includes a resuscitation room, mobile x-ray equipment, and a satellite laboratory in addition to triage and treatment spaces. It is based in the main hospital and has a dedicated patient access officer team to greet and register patients. In the 12 months prior to our inspection the UCC treated an average of 350 patients per month.

The Lister Hospital is home to a number of specialist units and teams including The Menopause Clinic and The Bunion Clinic. The hospital works closely with leading consultants across a range of medical disciplines.

The hospital provides treatment for private patients from the UK and overseas. Services are provided to both insured and self-pay private patients.

The registered manager for the location had been in place since March 2017.

The provider is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Surgical procedures
- Diagnostic and screening procedures
- Family planning
- Management of supply of blood and blood derived products

Diagnostic Imaging at The Lister Hospital was last inspected in 2017 as part of the Outpatients and Diagnostic Imaging core service, where it was rated as good overall and good in all domains. Since the last inspection, the outpatient and diagnostic imaging core services CQC inspection approach has been split into two separate core services.

To get to the heart of patients' experiences of care and treatment, we ask the same 5 questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate. Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Summary of this inspection

How we carried out this inspection

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

Outstanding practice

We found the following outstanding practice:

Urgent and emergency care

- The provider had a comprehensive programme of training and professional development focused on supporting patients with mental health needs. This exceeded the scope of the department and provided staff with skills to support patients with urgent needs relating to suicidal intent and self-harm before they were transferred to a more appropriate service. This approach reflected an embedded focus on monitoring patient outcomes and demand.
- Staff were demonstrably committed to diversity and inclusion as part of the provider's wider work to ensure care was accessible. Staff completed specialist training in diagnostics for transgender patients, which reduced barriers to care.
- Staff worked in an environment that promoted and facilitated evidence-based improvements and development, particularly in relation to data-led care and digital transformation.
- The service acted on learning from the local community and wider patient network and provided highly specialised signposting and support tools, particularly in relation to those suffering domestic violence.
- Staff continually developed multidisciplinary care pathways with specialist teams across the provider and with NHS colleagues. This led to demonstrably, quantifiable improvements in patient outcomes for those with rare or undiagnosed conditions.

Diagnostic imaging

- The radiology department had been awarded and maintained the Quality Standards in Imaging (QSI) Award since 2018. Accreditation is the formal recognition that an imaging services provider has demonstrated that it has the organisational competence to deliver against key performance measures. These measures require the department to achieve high standards of service in relation to patient care and choice, safety, fit-for-purpose facilities, and clinical practices.
- Staff were supported and encouraged to develop. The service had a learning academy and had developed a Competency in Administering Intravenous Injections for Radiographers course, which was recognised by the College of Radiographers.
- The service valued person-centred care, and had appointed learning disability and dementia champions.

Surgery

- The service's ethos was based on their commitment to patient wellbeing and care was exemplary. It was felt and said by patients that the service would go above and beyond to support them in their needs.
- The team worked diligently to minimise cancelled surgeries and reschedule them when this happened. Staff exceeded expectations in managing peoples, individual needs.
- Staff worked in an environment that promoted and facilitated evidence-based improvements and development with excellent governance processes, particularly in relation to data-led care and live digital information.
- The service proactively worked with wider health system to ensure patients had access to the best continued care before and after discharge.

Summary of this inspection

- The service was entrepreneurial and pioneering in their approach to innovation and improving patient care. This was particularly evident in their in vitro fertilisation unit.

Medical care

- The vision and values of the service were promoted by leaders and consistently demonstrated by staff in their daily work.
- The senior leadership team were highly visible, and staff spoke highly of the approachability and support they received from leaders.
- There were comprehensive and embedded governance systems that were used to drive improvements and support the delivery of high quality and person-centred care.
- Staff were respected and valued and received recognition for their work. There was a range of staff engagement processes.
- Innovation and continuous improvement were embedded into day-to-day practice and staff were encouraged to engage with developments.
- There was a range of patient engagement processes that included a patient forum, survey and daily engagement with senior staff to ensure patients' needs were met and action taken to ensure a high-quality experience of the service.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

- The hospital should ensure that updates to patient information are documented in all records relating to the patient's care. Regulation 12.

Urgent and emergency care

- The service should ensure that updates to patient information, such as allergies, are documented in all records relating to the patient's care. Regulation 12.
- The service should ensure staff understand the risk assessment relating to ligature points. Regulation 12.

Medical care

- The service should ensure that actions to improve fire safety on the ward have a project start date.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Critical care	Not inspected	Not inspected	Not inspected	Not inspected	Not inspected	Not inspected
Services for children & young people	Not inspected	Not inspected	Not inspected	Not inspected	Not inspected	Not inspected
Diagnostic imaging	Good	Inspected but not rated	Good	Good	☆ Outstanding	Good
Medical care (Including older people's care)	Good	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Outpatients	Good	Inspected but not rated	Good	Good	Good	Good
Surgery	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Overall	Good	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding

Critical care

Services for children & young people

Good

Diagnostic imaging

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

Is the service safe?

Good

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

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. Ninety four percent of staff had completed all mandatory training. The mandatory training was comprehensive and met the needs of patients and staff.

At the time of inspection, 71% of staff had completed training in immediate life support (ILS). Staff who had not completed it were booked onto the next available training course.

Medical staff kept up to date with their mandatory training. The service had 107 radiologists who held practicing privileges to work within the service. The radiologists were responsible for keeping up to date with their mandatory training and this was reviewed within their annual appraisals. At the time of inspection, 99% of radiologists had completed their annual appraisal, and had demonstrated that they were up to date with their mandatory training.

Clinical staff completed training on recognising and responding to patients with dementia, learning disabilities, and autism. Ninety-one percent of staff had completed the Oliver McGowan Training on learning disability and autism. This training had been developed to enable healthcare professionals to better support people with learning disabilities and autism. Staff told us that they had received training to enable them to better support patients with dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Ten out of 12 staff had completed safeguarding adults training to level 3 and the remaining 2 staff had completed safeguarding training to level 2.

Good

Diagnostic imaging

The service did not see children. Ten staff members had completed safeguarding children to level 2, and 5 staff members had completed safeguarding training to level 3.

Medical staff received training specific for their role on how to recognise and report abuse. Radiologists with practicing privileges were responsible for ensuring they remained up to date with their safeguarding training. This was reviewed as part of their annual medical appraisal.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff shared examples of what they would consider to be a safeguarding concern, including incidents of domestic violence. Staff were aware of female genital mutilation.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us that they would raise concerns with their manager and the safeguarding lead, who was the chief nursing officer for the service.

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.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The service followed the NHS national standards of healthcare cleanliness. Monthly audits took place which generated a star rating which was displayed within the department. For the year preceding the inspection, the cleaning score had remained above 98%. Any areas of non-compliance identified through audits would be rectified immediately. Staff told us that the imaging department was due to be refurbished in the month after our inspection. The service could not achieve 100% in the audits as there were scuffs on the walls. This would be rectified following the refurbishment. Cleaning standards were reviewed in the service's infection prevention and control (IPC) committee.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were bare below the elbow, which facilitates effective hand hygiene. Hand washing sinks were compliant with health technical memorandum (HTM) 64, and alcohol hand gel was readily available throughout the department.

Staff cleaned equipment after patient contact. We observed staff cleaning equipment after patient use within CT and MRI scanning rooms with disinfectant wipes. Staff used disinfectant sporicidal wipes to clean ultrasound probes and recorded each clean within a quality trail audit book, to ensure traceability. The system required the disinfectant foam to be in contact with the surface for at least 30 seconds, but not all staff were aware of the time required to leave the foam in contact in with probe.

Cleaning products and other chemicals were stored in secure locked cupboards, which complied with Control of Substances Hazardous to Health (COSHH) regulations.

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

Diagnostic imaging

The design of the environment followed national guidance. The service was compliant with Health Building Note (HBN) 6 – facilities for diagnostic imaging and interventional radiology. Privacy curtains and screens between the control rooms and scanning rooms were used to offer privacy and dignity to patients. Protective screens offered protection to staff from the risks of radiation where required.

We saw that a resuscitation trolley, emergency equipment and moving and handling aids, such as transfer boards, were readily available within each department. The resuscitation trolley had a signed checklist which demonstrated that daily checks had been completed.

Portable Appliance Testing (PAT) had been completed in the year preceding the inspection on electrical appliances within the department, which ensured they were safe to use.

The service used a Picture Archiving and Communication System (PACS), which was a secure integrated system which managed and stored all images and radiology-level patient information. This meant that doctors and healthcare professionals throughout the service had easy access to the imaging examinations. Staff within the radiology department could view previous images for each patient at this service.

All scanning rooms and the stock room were securely locked. Staff accessed these rooms with personal passkeys.

Reporting of diagnostic images was carried out in dimly lit rooms, on monitors which were back-lit. This created optimal ambient lighting for reporting on diagnostic images. The service was investing in height adjustable workstations for radiologists to work at.

Staff carried out safety checks of specialist equipment. Quality assurance (QA) testing on all equipment was carried out by staff at pre-determined intervals throughout the year. Details of all QA testing was outlined within the employer's procedures. Employer's procedures are written instructions detailing how the various aspects of radiation exposure of patients will be managed.

Radiation quality assurance on all imaging equipment was provided by an external company, who also provided radiation protection guidance through the services radiation protection advisor (RPA) and medical physics expert (MPE). Staff followed a QA testing manual which outlined the frequency of testing, the method and what results should be expected. The manual had been compiled by the radiation consultancy service. We saw that most equipment was tested every 2 months, and the results were stored on an online, cloud-based storage facility.

We saw a comprehensive list of MRI risk assessments, which were all in date. These included risk assessments for pregnant staff and risk assessments for liquid helium leaks.

We saw servicing records and maintenance contracts for equipment within the department. Equipment maintenance occurred at pre-arranged dates as detailed in the contract with the equipment vendors. Equipment servicing, also called planned preventative maintenance was conducted annually for medical devices across Lister Hospital by a certified engineer company.

The service had suitable facilities to meet the needs of patients. Changing rooms were available for patient's use. The changing rooms had call bells within them for patients to alert staff if they deteriorated or needed assistance when changing. The call bells were tested daily within the quality assurance testing. The service was accessible for disabled service users.

The service had enough suitable equipment to help them to safely care for patients. Lead personal protective equipment (PPE) was available to protect staff and carers who were required to be within the controlled area with family members. The PPE was QA checked in August 2023 and was due to be checked again in February 2024. Staff followed guidance to screen lead PPE for defects and assess suitability. Four items of PPE were removed from use in the imaging department following the last QA checks as defects were identified. The service had posters advising staff on how to wear the lead PPE correctly.

Staff disposed of clinical waste safely. Clinical waste was segregated according to health technical memorandum (HTM) 07-01. Sharps bins were dated and stored appropriately.

Assessing and responding to patient risk

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

Staff responded promptly to any sudden deterioration in a patient's health. There was dedicated medical cover and resuscitation team who provided support to the imaging department team.

Staff followed the services early warning scores policy and we saw that National Early Warning Scores (NEWS2) charts were available in the department. NEWS2 is a tool which improves the detection and response to clinical deterioration in adult patients. Staff told us they would call 2222 from internal phones in a medical emergency for the resuscitation team to attend.

Patients who were recognised as having a suspected or confirmed stroke were transferred to a hyper acute stroke unit at a nearby NHS hospital. Staff followed a standard operating procedure (SOP) which ensured that stroke patients were rapidly transferred in an ambulance to the appropriate setting. The service had a clear SOP for transferring critically unwell patients from theatres or critical care to the imaging department or to another hospital. The decision to transfer a patient requiring a higher level of care was only made by a consultant intensivist.

The department had 1 resuscitation trolley, which was easily accessible and contained the necessary equipment and medicines to treat adults in an emergency. The imaging department did not treat children, and it was rare for children to accompany patients to the department. Staff followed the service's cardiopulmonary resuscitation policy.

Staff told us what they would do if there was a medical emergency while a patient was having an MRI scan. MRI is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of inside the body. Due to the magnetic field, the resuscitation trolley is not allowed into the room. Staff told us they would immediately stop the MRI scan and staff who worked within the MRI department would evacuate the patient into a holding area, where emergency treatment could be administered to the patient, away from the strong magnetic fields. MRI staff had received evacuation training to ensure they could react effectively to a deteriorating patient within MRI.

Staff had completed regular simulation training for different types of medical emergency. The service had completed resuscitation simulation training in CT in September 2023. No actions had been identified following this training.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff followed the principles set out by the World Health Organisation (WHO) and the five

steps to safer surgery where invasive procedures were used. We saw SOPs which detailed the local safety standards for invasive procedures (LocSSIPs). These set out critical safety and quality steps required for invasive procedures and included guidance on surgical site marking, consent, safety briefing and the use of the WHO checklist, which had been adapted for radiological intervention use.

Staff followed policy on the process for gaining consent and identification of patients, by using 3 pieces of identifiable data. In addition, staff cross checked the site that was requested for imaging with the patient to ensure the patient referral was correct.

All patients attending for MRI completed a MRI safety questionnaire to check if patients had implants, pacemakers or aneurysm clips.

Staff knew about and dealt with any specific risk issues. Staff followed patient group directives (PGDs) and the safe administering of contrast media in diagnostic radiology guideline to administer contrast media within CT and MRI modalities. All imaging staff involved in administering contrast were ILS trained and trained to manage contrast reactions. Outpatients receiving contrast media were given an information leaflet which told them who to contact if they experienced a delayed reaction to the contrast.

Staff were aware of the risk of extravasation. Extravasation occurs when a medicine designed to be delivered directly into the vein accidentally leaks into the surrounding tissues instead. This can lead to tissue damage, skin irritation, and tissue necrosis. Extravasation boxes containing the necessary equipment to deal with extravasation were available within the MRI and CT scanning rooms.

Anaphylaxis boxes which contained the necessary medicines to deal with anaphylaxis reactions were readily available within the MRI, CT and the interventional scanning room. Hypoglycaemic boxes, which contained the necessary medicines to help patients who developed low blood sugar, were available in the CT and MRI scanning rooms. We saw that these boxes were checked by staff daily, to ensure that the medicines were available and in date.

Staff locked the doors to each room, to ensure no members of the public entered the room during a procedure. All rooms were locked and could only be accessed by staff with pass entry. Emergency stop buttons were easily accessible within the scanning rooms and warning lights marked that the rooms were controlled areas. Radiation signs were visible.

Lead PPE was readily available for staff and for patient's carers who were required to accompany and support patients within diagnostic x-ray rooms. The lead PPE was stored appropriately. Staff wore personal radiation dosimeters. They measured the amount of ionising radiation each staff member had been exposed to. The dosimeters were sent to an external company quarterly, to assess if each staff member had been exposed to excess radiation. The radiation protection supervisors received the results and if any staff member had received doses over the threshold, they were immediately notified. The radiation protection advisor (RPA) for the service would be notified, who would investigate and advise the service on the next measures.

Staff shared key information to keep patients safe when handing over their care to others. Reports on the diagnostic images were sent to the referring clinician within letters. Staff escalated unexpected or significant findings at examination and upon reporting immediately to the referring clinician.

Shift changes and handovers included all necessary key information to keep patients safe. Handovers took place twice throughout the day.

Good

Diagnostic imaging

Staffing

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

The imaging team covered MRI, CT, X-ray (including fluoroscopy and x-ray in theatres) and portable imaging. Staffing during operational hours included 2 reception staff, 2 registered nurses to support interventional procedures, 1 radiographic department assistant, 3 MRI senior radiographers, 2 CT senior radiographers, 2 x-ray senior radiographers and 1 manager. Over the weekend and out of hours, the service had 1 on call radiographer, 1 on call interventional radiology nurse and 1 consultant radiologist.

The service had 2 radiographers who provided a radiation protection supervisor role. This meant that they had received additional training in the Ionising Radiation Regulations 2017 and were responsible for ensuring compliance with the regulations and the local rules. The service had access to a radiation protection advisor (RPA) and medical physics expert (MPE) through a service level agreement with an external organisation. Staff could access them if there were radiation concerns relating to the equipment. Staff knew how to contact the radiation protection advisor for concerns in relation to compliance with the regulations or incidents involving radiation exposure. The RPA's contact details were clearly displayed on the Local Rules within each scanning room.

Consultant radiologists worked under practising privileges agreements. Under practising privileges, a medical practitioner is granted permission to work within an independent hospital. Practising privileges were granted to consultants by the medical executive committee. At the time of inspection, the service had 107 radiologist who were able to work at the service under practicing privileges.

The service had low vacancy rates. The service had recently promoted internal staff members to deputy imaging manager and a new CT superintendent role. A high proportion of staff were new to the service, with 5 out of 12 staff having joined in the last year. At the time of inspection, the service had 1 senior radiographer for MRI role vacant.

The service had low sickness rates. If a staff member was off sick, other staff usually volunteered to cover their shift. The service could access staff from other HCA hospitals when required. Staffing and capacity were reviewed daily and discussed in team huddles. Additional staffing could be allocated as and when required to reflect clinic volumes from other HCA hospitals or within the Lister Hospital.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The service had experienced staffing challenges in the year preceding our inspection. The imaging department was supported by the HCA Temporary Staffing Services, who booked agency and bank shifts for the imaging department. Staffing was rostered at least 1 month in advance and reviewed to ensure an appropriate skill set was available for cover. Staff were rostered across the modalities with consideration for skill set and sub-speciality knowledge on specific modalities, for example within CT and MRI. In the 6 months preceding our inspection, the imaging department had used bank staff for 10% of the time and agency staff for 1% of the time. Staff told us that the same bank staff were routinely used and they were familiar with the service, therefore there was no negative impact.

Managers made sure all bank and agency staff had a full induction and understood the service. The HCA temporary staffing services team ensured that bank staff had access to the mandatory training portal and had received orientation for each department on site. Bank staff completed a bank staff handbook, which outlined their competencies.

Recruitment needs were discussed within weekly meetings with the senior management team. Recruitment needs were merged centrally with the HCA team.

Records

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

Patient notes were comprehensive and all staff could access them easily. Records were stored securely. Patient records were paper based, which were then scanned onto a digital imaging display and storage system. Records included an imaging request form, which flagged any risks, such as allergies or diabetes. Referring practitioners could specify if they had a preferred radiologist to complete the reporting on the diagnostic images.

Records included confirmation that the operator had 'paused and checked'. This included a check that the examination was justified and there had been no other similar images completed recently. The identity of the patient had been confirmed the correct anatomical area had been selected. The use of 'pause and check' was audited and was at 100% compliance in the 3 months preceding our inspection.

We looked at 5 sets of patient records for patients of reproductive age. All 5 records included an inclusive pregnancy status form which had been fully completed and signed by the patient and a member of staff.

Radiologists completed their reports on the diagnostic images within reporting timescales as listed within the services imaging reporting policy. Clinically urgent findings were escalated to the referring doctor immediately via telephone, with the name and grade of the contacted doctor added to the radiology report. They used a voice recognition software to produce a report. Once signed off by the radiologist, the reports were emailed directly to the referrer through encrypted email. Administration staff ran a status report each day, to see if there were any outstanding diagnostic images that still required reports.

The service had plans to update the patient record system by October 2024. The new system would be more patient focused and would align to NHS coding of imaging examinations. The lack of an electronic referral system was on the services risk register. Control measures for this risk included having stop and check processes in place and ensuring staff training in all safety protocols were up to date.

When patients transferred to a new team, there were no delays in staff accessing their records. The service had close relationships with general practitioners within the area. All referring doctors would be checked by their General Medical Council number, to see if the referral could be accepted.

All radiographers were expected to recognise urgent findings on the imaging and make immediate contact with a suitable radiologist to initiate image review and report as soon as possible. For outpatients, staff ensured further provision of care was organised before the patient left.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. We saw patient group direction (PGDs) for the administration of 5 different medicines. PGDs allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription. The PGDs included details of any exclusion criteria, cautions, dose, route of administration and any potential adverse effects. The PGDs were signed by

the senior representative of the professional group using the PGD, senior pharmacist and senior doctor. Staff operating under the PGD were required to be assessed as competent in intravenous drug administration and reassessed every 2 years. The healthcare professional operating under the PGD signed to confirm they had read and understood the PGD and were competent.

IV pressure injectors were operated by radiographers who had received the training and signed off as competent.

Staff completed medicines records accurately and kept them up-to-date. Radiologists completed drug charts to indicate what medicines were used for each procedure.

Staff stored and managed most medicines and prescribing documents safely. There were robust systems and processes in place which assured that controlled drugs could be always accounted for. Only 2 members of staff had access to the keys, which were kept within a pin controlled key safe. The controlled drug logbook detailed the batch numbers and expiry dates of each medicine. Each time a medicine was used, this was logged against the patient's name, date and time, quantity given and received. The stock was then balanced. Administration of a controlled drug was witnessed by a second person, who signed the controlled drug logbook.

Medicines were stored securely within locked cabinets in each imaging room. Contrast agents were stored within warming cupboards, which kept the contrast warmed to body temperature. Staff completed daily checks on medicines and logs of fridge temperatures to ensure all medicines were stored at the correct temperature. We saw daily temperature checks had been completed in the MRI scanning room.

Pharmacy staff carried out quarterly audits of the department's medicines and controlled drugs. The safe and secure storage of medicine audit looked at if medicines were stored correctly, and within locked or access-controlled rooms and locked cupboards, and if temperature monitoring was undertaken daily. We saw that this audit had identified that a liquid bottle of medicine which was in use did not have an opened date sticker on it. A memo was re-circulated to all staff to remind them to complete these stickers. The service had scored 100% compliance in the 3 audits which followed this incident.

The controlled drugs audit looked at if the CD logbook had been completed correctly, including having 2 authorised signatures for each entry and if the physical count of all CDs corresponded with the balance record in the CD register. The department had scored 100% compliance for the year preceding our inspection.

Results from the pharmacy audit were reviewed immediately by the team and further disseminated through the medication management committee and quality improvement group. SMART (specific, measurable, achievable, realistic and timely) action plans were developed against any noted areas of non-compliance.

Medical gas cylinders were stored appropriately.

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.

Staff knew what incidents to report and how to report them. The imaging department had a strong reporting and learning culture. Staff followed the services incident management policy which described the process for reporting and

managing clinical and non-clinical incidents. The policy supported the requirements of the national Patient Safety Incident Response framework (PSIRF). Staff told us they were encouraged to report incidents and gave examples of incidents that they had reported. One example was when the wrong side was requested for an extremity scan. Even though the correct side was scanned, staff reported this as an incident. Staff told us that immediate action would be taken to ensure the safety of those involved in the incident before escalating to their managers.

The service had 1 never event in the year preceding our inspection. Never events are serious, largely preventable safety incidents that should not occur if the available preventative measures are implemented. The never event occurred due to a non-adherence to process, including the 'stop before you block' protocol. Refresher training was organised immediately and the 'stop before you block' resources were recirculated to all staff. We saw that learning following the never event was disseminated within the hospital and across to other HCA services.

The diagnostic imaging department had reported 13 incidents between August 2023 and October 2023; 12 of these were classed as no harm and 1 had been classed as near miss. Nine of these incidents related to issues with duplication of patient numbers. The service had implemented an ongoing programme of support and training for staff who register or schedule patients for appointments, to establish if the patient had been seen at the service previously and to avoid a duplication of patient records.

Managers shared learning about never events with their staff and across the service. Staff told us that incidents were discussed within staff meetings and in incident review meetings. Staff received the meeting minutes for these meetings. The chief nursing executive was responsible for using the data and outcomes from incidents to inform quality improvement programmes and to ensure learning was shared with the wider team. Lessons learnt were presented on shared learning slides, which were emailed to staff members. The shared learning slides were discussed at departmental meetings and in quality improvement group meetings.

Staff reported serious incidents clearly and in line with the service's policy. The radiation protection supervisor (RPS) told us that any radiation incidents would be discussed within staff meetings and escalated to the RPA, who was external to the service. We saw the RPA had reviewed the radiation incident form following the never event.

Staff received feedback from investigation of incidents, both internal and external to the service. They told us that all incidents would be seen as a learning opportunity. Incidents which occurred at other HCA sites were shared with staff from the Lister Hospital.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. They followed the service's open communication with patients, including duty of candour policy.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The services head of patient safety and learning was responsible for leading patient safety incident investigations, driving improvements and advising staff on patient safety incident responses.

Managers debriefed and supported staff after any serious incident. All individuals involved in incidents were offered support and guidance from their line manager, who aimed to empower them to reflect and learn from the incident.

Is the service effective?

Good

Diagnostic imaging

Inspected but not rated

We do not currently rate effective in diagnostic imaging services. However, we found:

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. Policies and standard operating procedures (SOPs) referenced guidance from the National Institute for Health and Care Excellence (NICE), as well as the Royal College of Radiologists and the Society and College of Radiographers (SCoR).

The service used a tool to help healthcare professionals to choose the best, safest and most appropriate imaging test for their patients. This tool provided evidence-based guidelines which had been published by the Royal College of Radiologists to help ensure that referrals for imaging were appropriate. This helped promote optimal care for patients, support rapid diagnosis and avoided unnecessary ionising radiation.

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 for the Quality Standard for Imaging (QSI) accreditation from the Royal College of Radiologists and the College of Radiographers.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The imaging department had a comprehensive audit schedule. Different staff members were allocated specific audits to carry out at fixed intervals. Monthly audits included, but were not limited to, hand hygiene, health and safety, infection protection and control, medical devices and PGD audits. Audits on patient records, including the use of pause and check and gaining consent were completed every 3 months.

Staff were actively engaged in monitoring and improving the quality and outcomes of the service. Results from the audits were discussed in monthly staff meetings. Action plans were developed if the audits had identified areas of improvement. Any issues were escalated to the quality improvement group, which was led by the local governance team.

Managers shared and made sure staff understood information from the audits. Each month, every department received their audit results and a summary of any non-compliant questions. The summary gave staff the opportunity to document what was working well, any gaps identified and actions for the following month.

Improvement was checked and monitored. Actions from previous action plans were discussed within staff meetings each month, to check if actions had been completed. We saw that environmental audits had not achieved 100% compliance as the service was planning for the unit to be refurbished, as there were scuffs on the walls. The refurbishment was planned for the month following our inspection.

The service had Quality Standard for Imaging (QSI) accreditation from the Royal College of Radiologists and the College of Radiographers. Accreditation is the formal recognition that an imaging services provider has demonstrated that it has the organisational competence to deliver against key performance measures. These measures require the department

to achieve high standards of service in relation to patient care and choice, safety, fit-for-purpose facilities, and clinical practices. The imaging department at The Lister Hospital was 1 of only 8 centres to have gained QSI accreditation in London and was the only independent hospital-based imaging department to have achieved QSI. Through the QSI accreditation the department engaged in a continuous improvement cycle.

The service had been re-accredited against the 2019 QSI service standards and were working towards the transition to new QSI standards.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers held a skill matrix, which detailed which modality each staff member had completed competency training in, for example CT or MRI. Some staff could work across different modalities, while others only worked on MRI.

Managers gave all new staff a full induction tailored to their role before they started work, including bank staff.

Managers supported staff to develop through constructive appraisals of their work. The continuing development of staff's skills, competence and knowledge was recognised as being integral to ensuring high quality care. Radiology staff had 2 performance reviews throughout the year. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. The performance reviews looked at mandatory training and discussed future role and personal objectives for each staff member. We saw that a staff member wanted to complete additional training so they could complete x-ray quality assurance in the department. The performance reviews included due dates and when the objectives should be completed.

The service had 107 radiologists who held practicing privileges to work within the service. The radiologists received annual appraisals. Compliance with practicing privileges was reported to the medical advisory committee.

The departments training co-ordinator supported the learning and development needs of staff. Managers made sure staff received any specialist training for their role. Staff told us that there were various opportunities to develop their skills and progress. This included cannulation training, advanced PACs training, and management and leadership courses. HCA had developed a Learning Academy Portal, which allowed staff members to access both in person and virtual training. Staff were encouraged to discuss other learning opportunities which were not available through this pathway with managers, who supported staff to secure other opportunities to develop. We saw that funding had been approved for staff to attend courses in sedation, breast care nursing and cardiac MRI courses in the month preceding our inspection.

Staff could access an online personalised learning experience package for leadership and management development.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Important information was also disseminated through monthly newsletters.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The services corporate education, training and development policy stated, 'Education, training and

development in its broadest sense is central to the continued delivery of high quality safe and effective health services that are responsive to people's needs. HCA UK needs to ensure that staff are appropriately equipped and skilled to undertake their role and is committed to ensuring that all staff learn and develop appropriately to meet the needs of the company's strategic aims and key objectives.'

Multidisciplinary working

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

Patients could see all the health professionals involved in their care at one-stop clinics. One-stop breast clinics were available, with breast MRI scans used along with mammograms. Breast MRI scans can locate smaller breast lesions and lobular breast cancer, and are useful for scanning younger women with dense breast tissue. Patients requiring mammography were seen at a nearby satellite site. The 1-Stop breast pathway was a direct referral from BUPA and bypassed the need for a GP referral. As the triple assessment was preauthorised, it allowed rapid access to the breast service.

The service provided rapid access to prostate MRI scanning prior to prostate biopsies, which supported the fusion biopsy pathway. The fusion pathway used targeted biopsies of suspicious lesions, where a small number of tissue samples are taken.

The service was committed to working collaboratively and had found efficient ways to deliver joined-up care to people who used the service. Staff told us that the service had close relationships with many of the general practitioners (GPs) in the area. GPs could select a preferred radiologist to complete the report.

Staff worked across health care disciplines and with other agencies when required to care for patients. The service considered referrals for imaging examinations from General Medical Council (GMC) registered medical professionals. In certain cases, and where it was in the best interests of the patient, the service accepted referrals from registered healthcare professionals who were not medically qualified. The service had non-medical referral protocols in place which enabled eligible healthcare professionals to refer patients for x-rays. Non-medical referrers applied through the chair of the ionising radiation user group and approval was confirmed though the local radiation protection committee. Non-medical referrers were required to undertake radiation protection training, and sign to confirm that they would only make referrals within their scope of practice and to act upon the findings of the radiology reports.

Seven-day services

Key services were available to support timely patient care.

The imaging department operated 24 hours a day, 7 days a week to support the Urgent Care department and inpatient wards. It was open for outpatient appointments between 9am and 5pm Monday to Friday.

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.

Good

Diagnostic imaging

Staff gained consent from patients for their care and treatment in line with legislation and guidance. They followed the consent and capacity to consent policy which provided a framework for staff to obtain valid consent for the care and treatment they provide. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. The service's consent and capacity to consent policy stated, 'Where an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves, no-one else can give consent on their behalf except in some circumstances where a Lasting Power of Attorney applies, or a deputy has been appointed by a court. However, treatment may be given if it is in their best interests, as long as it has not been refused in advance in a valid and applicable 'Advanced Decision'.

Staff made sure patients consented to treatment based on all the information available. They understood the importance of working in partnership with patients and providing them with enough information to enable informed and valid consent, including detailing the risks and alternatives for treatment.

Staff clearly recorded consent in the patients' records. We saw consent forms within 5 patient records.

Staff received and kept up to date with training in the Mental Capacity Act. All staff had completed training in the Mental Capacity Act.

Is the service caring?

Good

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Privacy glass was used between the MRI and CT scanning rooms and the control room. We saw privacy glass being used during a breast MRI scan.

Appointment times were made longer if required. Staff told us that patients with learning disabilities or dementia were called before their appointment, to see if any additional support or time was required.

All patients were asked if they wanted a chaperone, and we saw posters in the department informing patients about chaperones. Chaperone forms were included in patient records.

Patients said staff treated them well and with kindness. One patient said, 'I really liked how they spoke to me part way through the MRI scan as its quite claustrophobic in the tube,' and another said 'I received outstanding care. I feel very lucky.'

Good

Diagnostic imaging

The service had introduced a Be Exceptional Every Day (BEE) award, which gave patients and their families an opportunity to vote for allied health professionals. We saw that a radiology department assistant had been nominated for the BEE award in the year preceding our inspection. A nurse from the imaging department was nominated for the Daisy Awards scheme. The Daisy Award is a recognition program to celebrate and recognize nurses by collecting nominations from patients, families, and co-workers.

Staff demonstrated going above and beyond for a patient who had a cochlear implant by reaching out to the manufacturer to obtain a specific MRI fixation kit be acquired to facilitate an MRI scan safely. The kit required was implant specific and only the manufacturer could provide it. The MRI lead contacted the manufacturer, and explained the situation and the urgency. By liaising with the manufacturer, the patient was scanned the following day.

Staff followed policy to keep patient care and treatment confidential. They followed the consent and capacity to consent policy which provided a framework for staff to obtain valid consent for the care and treatment they provide.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. The service had adopted an inclusive pregnancy status form, which was used to ascertain the pregnancy status of all service users between the ages of 12 and 55. Under the Gender Recognition Act 2004, gender reassignment is a protected characteristic. There was a recognition that every individual should be provided with adequate information relating to the benefits and risk associated with radiation doses and pregnancy, to allow patients to make an informed choice without the need to asking about their gender. We saw that the inclusive pregnancy status form was included in 5 sets of patient records.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff within the department often encountered patients who were needle phobic and claustrophobic. Staff were compassionate to their needs and took time to treat them with kindness to support them throughout their procedures. Patients were provided with a choice of ear plugs or headphones to listen to music within the MRI scanner. Eye masks or a head coil and mirror were offered to claustrophobic patients, to try and make the procedure more bearable for them.

Staff told us that they had communicated with an autistic patients' carers prior to an appointment. It was arranged that the patient could take a soft toy into the scanning room. This helped the procedure to be more bearable for them.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. The service had recognised that there was a lack of private waiting areas or rooms within the department, which made it difficult to uphold the privacy and dignity of patients within the imaging department while waiting for their procedures. There were plans to improve this situation with a refurbishment which was due to start in December 2023. Inpatients were prioritised for imaging to ensure their privacy and dignity were maintained and were not left waiting in communal areas. Outpatients were prioritised to ensure longer wait times were avoided and measures were taken to ensure that confidential information was shared with patients appropriately and not in communal areas.

Staff told us that any immediate concerns were communicated to the referring clinician as soon as possible. If clinicians were required to deliver bad news to the patient and their families, this would be done within the treatment rooms and in private.

Good

Diagnostic imaging

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. Staff could access interpreter services, including British Sign Language.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service participated in The Lister Hospital patient experience survey. Staff encouraged patients to complete the survey which was accessed via a quick response (QR) code. The service had implemented a 'feedback Friday' initiative, where staff sat with their patients following their examination to obtain contemporaneous feedback on access and experience.

Following receipt of the patient experience data, positive comments were shared with the team. Concerns were reviewed and added to the departmental action plan which was reviewed in monthly patient experience meetings.

Patients gave positive feedback about the service. One patient said, 'wonderful staff. My concerns were listened to and dealt with' and another said, 'very pleasant staff which makes the experience far easier to bear.'

Is the service responsive?

Good

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

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of 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 their population. Department leads had weekly calls with the appointments team to ensure that the service was immediately responsive to service requirements. For example, Saturday and Sunday MRI scanning slots were recently added in response to patient demand.

The imaging department had introduced a voice recognition software in March 2023 which had a critical alert function. This was used by radiologists to urgently flag unexpected findings with the referring clinician.

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. There were several one-stop clinics to allow consultation, investigations and treatment at the same time. Diagnostic leads and the outpatient teams worked closely together to forecast daily demand and ensured appropriate capacity was available.

Facilities and premises were appropriate for the services being delivered. The service was accessible for people with disabilities, with ramps and lifts available to use. The maximum weight limit for patients attending for an MRI scan was 180kg and 300kg for patients attending for a CT scan. The service did not see paediatric patients. Children were referred to other HCA hospitals.

Good

Diagnostic imaging

Staff could access mental health support for patients with mental health problems, learning disabilities and dementia. The service worked in partnership with another independent service provider of cognitive healthcare, and could offer referrals to psychiatrists, psychologists, therapists and coaches if required.

The service relieved pressure on other departments when they could treat patients in a day. The service liaised with other diagnostic imaging departments within HCA and were able to refer patients to other HCA facilities when required.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The service had appointed learning disability champions and dementia champions. They supported staff when treating patients with learning disabilities and dementia. Staff told us that longer appointment times would be booked for patients who may need additional time and support throughout their procedure. A dementia resources folder was readily available for staff to use which included 'This is me' forms. This is me forms are intended to provide information about the person with dementia as an individual and are designed to enhance the care and support that person receives.

Staff told us that the learning disabilities champions had worked on adapting the appointment letters, to make them easier to understand.

The service had information leaflets available in languages spoken by the patients and local community. Information leaflets were available in English and Arabic.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us that interpreters were organised for patients who required translator services. Interpreters explained the information leaflets, including post-operative instructions to those patients. Translator services could also be arranged over the telephone 24 hours a day. Staff told us that family members or staff who spoke that language would only be used to interpret in extraordinary circumstances.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Routine appointments were normally offered within 7 days. Urgent slots for the MRI scanner were protected each day, with 1 hour protected for inpatients who may need an emergency scan and 2 or 3 30-minute slots for outpatients attending the urgent care centre.

The Lister Hospital prided itself on its responsiveness to patient requests. The imaging department did not have any delays in treatment and did not operate a waiting list. One-Stop clinics allowed consultation, investigations & treatment at the same time. All appointment requests were well below the national NHS target of 31 days. The service ensured there was on the day diagnostic capacity available for patients, with the diagnostic leads and outpatient teams working closely together to forecast on the day demand.

Good

Diagnostic imaging

The imaging service operated 24 hours a day for emergency scans for inpatients and the urgent care centre, which operated from 8am to 8pm. Radiologists and a supporting team of radiographers were allocated to be on call on a weekly basis. Some radiologists covered multiple modalities (such as MRI and CT). The duty manger contacted the on-call team when required.

The service carried out a regular audit to look at waiting times within ultrasound. This audit looked at if clinical staff greeted patients within 5 minutes after their arrival. Last compliance was 90%.

Reporting on diagnostic images was completed within timescales outlined in the service's imaging reporting policy. Urgent imaging was prioritised, with clinically urgent reporting targets of within 4 hours. Any delays were escalated to the imaging services manager. Daily data reports from the electronic patient record were evaluated. They showed the length of time each examination had been waiting to be reported, and the radiologist that it had been allocated to. Any diagnostic images without a report for over 24-hours were flagged and followed up with the reporting radiologist. The service's reporting turnaround time KPI was under 48 hours for all standard (non-urgent) imaging requests. Audits which looked at reporting times were consistently over 90%.

Managers worked to keep the number of cancelled appointments to a minimum. Patients were offered to be seen at another HCA hospital if their appointments needed to be cancelled. Appointments were rarely cancelled, but there had been occasions when patients had to be rescheduled or seen at another HCA hospital for example, when the CT scanner had an artifact and the pressure injector in CT had broken down. On another occasion, there had been a sensor issue within the interventional room, and the bed failed to tip. Patients were rebooked at another HCA hospital. Staff followed the service's downtime procedures.

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. We saw posters which informed service users on how to leave feedback through a patient experience survey. Staff encouraged patients to complete the survey which was accessed via a QR code. As not all service users remembered to give feedback following their appointments, the service had adopted 'Feedback Fridays', where staff sat with patients to gain real time feedback.

The hospital had a patient forum and patients were actively encouraged to participate.

Staff understood the policy on complaints and knew how to handle them. Patient complaints were managed in line with the HCA complaints policy. The timelines on how complaints were managed were included in the complaints policy, with acknowledgement letters sent within 3 days of receiving the complaint and full written responses sent within 20 days.

Patients were offered a complaints booklet when required, which explained the complaints process. The service subscribed to the Independent Sector Complaints Adjudication service (ISCAS) which provided a complaints management framework.

Good

Diagnostic imaging

Managers investigated complaints and identified themes. The service had received 1 complaint in the 3 months prior to our inspection. The complaint related to difficulties in booking an appointment. The service had taken measures to address the complaint and had reviewed the booking process with a consultant's secretary.

Managers shared feedback from complaints with staff and learning was used to improve the service. Following receipt of data from the patient experience survey, positive comments were shared with the team and any concerns were reviewed and added to the departmental action plan. Patient feedback was reviewed in monthly patient experience meetings.

Staff could give examples of how they used patient feedback to improve daily practice. They told us that the service now offered gowns in larger sizes following patient feedback.

The service participated in the "You Said, We Did" campaign. The service had received feedback that patients did not always have information about the examination they were having ahead of the appointment. Patient information leaflets were introduced, to include information on MRI, transvaginal and pelvic ultrasounds, x-rays and bone density scans.

Is the service well-led?

Outstanding ☆

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

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 Head of Imaging Services had been in post for 13 years, having worked at the hospital for 24 years within different roles as an imaging manager and superintendent roles. They had seen the service evolve and change in those years and through 5 different CEOs of the service. They had played a vital role in achieving and maintaining the QSI accreditation and in implementing additional training opportunities for staff.

Staff told us that the head of imaging was approachable, and had an open-door policy. Staff told us, 'They always have 5 minutes for us to talk to them.' It was evident that the Head of Imaging was immensely proud of the imaging team.

The Head of Imaging Services was aware of the challenges that the service faced, including staffing challenges and the difficulties around having the service in an older building. They had a good oversight of the current risks and told us of mitigations that had been taken to address these risks.

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.

Good

Diagnostic imaging

HCA's mission was 'above all else we are committed to the care and improvement of human life'. HCA had 4 values which helped to bring the mission to life in daily work:

- To recognise and value everyone as individual.
- To treat people with kindness and compassion.
- To act with absolute honesty, integrity and fairness.
- To trust other staff members as valued members of the HCA UK family with loyalty, respect and dignity.

Putting patients first was at the heart of the services values.

Staff discussed HCA values and behaviours within their performance reviews. Supporting the development of staff was one of the key strategic enablers of the services 5-year organisational strategy.

The imaging department had also adopted the Quality Standard for Imaging (QSI) vision and strategy. This included:

- To keep people safe by regularly reviewing the quality of the service and maintaining patient's privacy and dignity.
- Staff to always treat patients with respect, explain examinations and give patients time to ask any questions.
- To listen to patients' feedback to help improve the service.
- To maintain the highest standards.

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.

Leaders strived to deliver and motivate staff to succeed. The service had a departmental employee of the month award, where colleagues nominated a team member who had inspired them during that month. This initiative complimented the Daisy and BEE Awards, which were recognition programmes which celebrated and recognised nurses by collecting nominations from patients, families, and co-workers.

There was a strong organisational commitment to ensure equality and inclusion across the workforce. The Lister Hospital had an active equality and inclusion group that met bi-monthly. Staff from the imaging department were active participants. This group had introduced prayer mats for satellite sites.

In May 2023, The Lister Hospital introduced the Society of Radiographers (SoR) sex, identity gender and expression (SIGE) inclusive pregnancy (IPS) form.

Good

Diagnostic imaging

The service carried out biannual staff surveys. A staff survey carried out in October 2023 had a 69% response rate. The survey found that 85% of staff within the imaging department felt they were treated with dignity and respect and 80% felt that managers cared for them as a person. However, only 50% of staff felt their career goals could be met and 55% felt they had the resources to do their job well. Staff who we spoke with demonstrated a sense of pride to work at the service.

Following a staff survey in October 2022, staff had asked for additional communication and recognition. In response the department implemented informal newsletters to introduce new team members and highlight any social news and events. This was in addition to a more formal update newsletter to update team members on departmental business news. This initiative improved cross departmental communication and staff fed back that they felt more aware of departmental news and initiatives.

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 Lister Hospital had a cohesive quality governance framework in place, with governance meetings taking place either weekly, monthly or quarterly. The service had clear processes and a supporting infrastructure which assured accountability. Radiation protection governance was included in this infrastructure. Quality governance frameworks were incorporated into every level of the hospital through a variety of processes, which ensured key messages and oversight from ward to board and board to ward. The frameworks aimed to drive continual improvement, evidence-based practice, shared learning from errors and near misses, and to act upon feedback from patients. Information and actions were filtered up from and down to frontline staff and appropriate resources and improvement initiatives were fed down to staff to help provide high standards of patient care.

The Lister Hospital undertook quarterly radiation protection committee meetings. The local radiation protection committee (RPC) was responsible for ensuring radiation was managed appropriately and according to legislative requirements. Extraordinary meetings were held if required. Staff told us that an extraordinary meeting was held following a never event at the service. Outcomes from the local radiation protection committee fed into the corporate radiation protection committee, which covered 7 other HCA services, and up to the health and safety risk board, quality and safety board and executive board. The local RPC gave assurance to the corporate RPC on a quarterly basis and ensured all urgent issues were escalated through the local governance structure. We saw meeting minutes for the RPC meeting held in July 2023, where the replacement of the fluoroscopy machine was discussed and added onto the risk register, and the success of the implementation of the inclusive pregnancy status form was discussed. A decision was made in this meeting to have 2 named staff members who would be responsible for ensuring that all staff in theatres have dose monitoring badges monthly. RPC meetings also covered recent audits and incidents.

Radiation user group (RUG) meetings for ionising and non-ionising radiation were held quarterly and exceptions were reported to the RPC for discussion and review. Representatives from each RUG attended the RPC meetings and ensured key messages from the local RPC were shared with RUG members. We saw meeting minutes for 6 RUG meetings, including the extraordinary RUG meeting held after the never event. The management of high-risk patients and changes to the standard operating procedure for these patients was discussed in the meeting in March 2023.

The medicine advisory committee considered submissions for practicing privileges. They considered if there was a requirement for that type of speciality at the time. Staff told us that the service needed more interventional radiologists in the year preceding the inspection but had an excess of other specialities.

Good

Diagnostic imaging

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.

The imaging department held a risk register which outlined identified risks and explained control measures to mitigate the risk. Each risk was assigned a score, depending on the severity and impact of each risk. One risk listed was that the CT injector which was used to administer contrast injections was nearing the end of its life. We saw that a new CT injector had been ordered and was expected to be delivered by December 2023. The control measure in place was to assess all referrals and book those cases requiring a CT injector to be used into another HCA site.

Ten percent of all imaging reports were peer reviewed across specialities and modalities. The service had introduced double blind reporting in CT and MRI to ensure high standards of reporting in complex cross-sectional imaging. All discrepancies were reported to the imaging services manager and categorised depending on the severity and impact of the discrepancy. Any serious misses would be reported as an incident and investigated.

The service conducted an 'MRI examination to report time' audit which looked at the turnaround times between image completion and the consultant receiving the report. During September 2023, 97% of images were reported in within 48 hours, with 82% being reported on within 24 hours. The service took action to remind all MRI staff to check the previous days reports with the aim to achieving 100% compliance for the next audit.

The service followed the HCA Healthcare UK Capital Policy. Towards the end of each financial year heads of department were invited to present their department capital requests to the senior management team. The senior management team held quarterly capital review meetings to consider new and unforeseen department requests. We saw that the service had requested a new CT injector. Earlier in the year, the service had invested in a refurbishment of an MRI scanner. Staff told us they had seen a dramatic improvement in the image quality following the refurbishment. The service was also investing in refurbishing the flooring in the imaging corridor.

Radiation contingency plans were included in the local rules which outlined the contingency plans within each modality for all reasonably foreseeable events. This included measures to take if there was a failure to terminate an exposure or failure of equipment.

The service had contingency arrangements in place for reporting on images if there was IT downtime and business continuity strategies in place for a variety of events, such as lack of staff, loss of utilities such as water, and equipment breakdowns.

Local rules were available in each scanning room and on imaging equipment used within the theatres. Local rules identify key working instructions to ensure that exposure to staff or others to radiation is restricted. Details of the RPA were clearly documented on the local rules.

Diagnostic Reference Levels (DRLs) are dose levels for typical examinations on standard sized patients for broadly defined types of equipment. The DRL list was reviewed annually by the Radiation Protection Committee and guided by recommendations from the MPE.

Good

Diagnostic imaging

The imaging department had a strong reporting and learning culture. Staff knew how to report incidents and near misses. Incidents were discussed within staff meetings and in incident review meetings. Lessons learnt were presented on shared learning slides, which were emailed to staff members. The shared learning slides were discussed at departmental meetings and in quality improvement group meetings.

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 imaging department measured and monitored performance through a comprehensive audit schedule. Results were reviewed immediately by the team and further disseminated through the imaging team meetings and quality improvement group led by the local governance team.

We saw a commitment in sharing data and information to proactively drive improvement and support internal decision making, as well as a system wide working improvement. Each month, every department received their audit results and a summary of any non-compliant questions. We saw that the imaging department was non-compliant on the recent health and safety and IPC principles and practices audits due to the department being due for refurbishment in the month after our inspection. These audits had identified that the floors and walls had slight damage and therefore they could not achieve compliance with these audits. The inspection team did not notice any significant damage to the walls or floors, which demonstrated the high standards that the service held itself to account for. During October 2023, the imaging department had achieved 100% compliance in the WHO checklists, chaperone documentation and the use of patient group directions. On completion of audits, the results and findings were presented at the facility audit, governance and quality meetings for discussion. Action plans were discussed and decisions made on when to complete another audit cycle within a designated timeframe. Audit results were escalated when required to the corporate audit group, corporate audit committee and clinical governance committee.

The Lister Hospital pharmacy team carried out quarterly medicine's audits. Results and findings were presented at the Lister Hospital quality improvement group for discussion and action plans. When required, shared learning or process reviews following these medicine audits were shared with the corporate audit committee, clinical governance committee and the pharmacy quality group.

The service completed an audit to monitor the ultrasound waiting times. Data was collected by administration staff over a period of a week. The service aimed for all patients to be seen within 15 minutes of registration, and once registered, patients should be called to ultrasound within minutes. The sample size was 20 patients. The audit found that 18 of the 20 patients were seen within 15 minutes. The 2 patients who were over 20 minutes were due to 1 patient having an MRI scan first, whose appointment overran and the other patient's appointment was delayed due to an urgent patient being fitted in before them. Action taken following this audit was to review the process when making multiple appointments for patients to allow more time and ensure no delays.

The service had reported the never event appropriately to CQC.

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 service had access through a service level agreement to a medical physics expert, who was also the radiation protection advisor for the service. We saw the contact details for the RPA were clearly documented on the local rules within each department and on equipment. The RPA was readily available when required and responsive to the service's needs. The RPA made themselves available to speak to the CQC inspection team on the day of inspection. The RPA carried out annual quality assurance (QA) testing of equipment and equipment handovers.

The service had appointed 2 medical advisory committee leads, who represented the department within quarterly medical advisory committee meetings. These meetings discussed topics such as the governance of the service and practicing privileges.

Discrepancies in reporting were discussed in radiology events and learning meetings (REALMS) which were held across HCA hospitals and different subspecialities attended. The Lister hospital hosted a REALMS meeting in June 2023. These meetings provided a forum for discussions around best practice and to review and share leanings from incidents. We saw that the never event was discussed at this meeting along with 5 other cases.

The service collected patient feedback through a patient experience survey accessed by a QR code, and directly from patients each Friday. Following receipt of data from the patient experience survey, positive comments were shared with the team and any concerns were reviewed and added to the departmental action plan. Patient feedback was reviewed in monthly patient experience meetings.

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.

The imaging teams aimed to develop services through continuous learning and quality improvement programmes, with a fully embedded and systematic approach to improvement. There was a strong emphasis on providing staff with opportunities to grow and progress. The service had a learning academy where face to face training was delivered. Staff completed their safeguarding training, learning disability and autism training and learning disability champion training at the academy.

The services learn and grow brochure was available to all staff and outlined development support and opportunities available to all staff.

The service had Quality Standard for Imaging (QSI) accreditation from the Royal College of Radiologists and the College of Radiographers since 2018. Accreditation is the formal recognition that an imaging services provider has demonstrated that it has the organisational competence to deliver against key performance measures. These measures require the department to achieve high standards of service in relation to patient care and choice, safety, fit-for-purpose facilities, and clinical practices. The imaging department at The Lister Hospital was 1 of only 8 centres to have gained QSI accreditation in London and was the only independent hospital-based imaging department in the country to have achieved QSI accreditation.

HCA UK had partnered with London South Bank University to train student radiographers and strengthen the HCA UK imaging workforce. The service trained 2 staff members to be radiography student practice facilitators to support the

students. Students worked closely with the practice facilitators on site, along with other members of the workforce, getting a wide range of learning opportunities. The service had a standard operating procedure to aid radiographers to supervise and provide an appropriate learning environment for the students. The imaging service line lead presented guest lectures to the South Bank University students.

The service had supported a radiology department assistant, who had studied as a radiographer in another country, to train and be able to register as a HCPC radiographer. Staff told us that the service was very supportive in helping them to develop their skills and progress.

The service had developed a Competency in Administering Intravenous Injections for Radiographers course, which was approved and recognised by the College of Radiographers. HCA was one of the first hospital groups to have this training recognised by the College of Radiographers. Radiographers could train in-house and receive a UK recognised training qualification.

One of the service's superintendent radiographers had recognised a significant gap in MRI safety knowledge both locally and nationally. This staff member was also a magnetic resonance safety officer. Following a year of research and collaboration with peers and national experts in the field, they developed a comprehensive MRI e-learning safety tool. This was submitted to the Society of Radiographers board, where it received a CPD certificate of endorsement. This tool was mapped onto every learning pathway of clinical and non-clinical staff who had access to an MRI environment in HCA Healthcare UK.

The Lister Hospital had been at the forefront of robotic surgery as they had been directly involved with the Mako orthopaedic robotic surgical system. This system allows for a much more accurate placement of joint implants compared to more traditional joint replacement methods. The imaging service provided more advanced diagnostic imaging such as preoperative CT scans to assist in preoperative mapping and planning for Mako hip surgery. The Mako uses a combination of a virtual 3D model through pre-op CT and intraoperative bone registration. This technique increased the opportunity to offer partial knee replacements over total knee replacement and helped to reduce the length of hospital stays.

Outstanding

Medical care (Including older people's care)

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

Is the service safe?

Good

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

Mandatory training

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

Staff received and kept up to date with their mandatory training. Overall mandatory training compliance for the medical service was 96% against a target of 95%. Mandatory training compliance for the endoscopy department was 100%.

The mandatory training was comprehensive and met the needs of patients and staff. Modules included basic or immediate life support, sepsis, infection control, fire safety and moving and handling.

Managers monitored mandatory training and alerted staff when they needed to update their training. They used a traffic light system to notify them when training needed to be booked. This was reviewed by the hospital learning academy who notified managers when staff needed to complete training updates.

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.

All medical and nursing staff received training specific for their role on how to recognise and report abuse. Clinical staff completed safeguarding adult training at level 3 and compliance was at 90%. They completed child safeguarding training at level 2 and compliance was at 100%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. They had completed equality and diversity training and had an understanding of protected characteristics. Staff we spoke with gave examples of how they protected patients and there were clear escalation processes for when concerns were raised.

Outstanding ☆

Medical care (Including older people's care)

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. They knew that the chief nursing officer was the safeguarding lead, and that corporate safeguarding support and leadership was also available and leads were trained to safeguarding level 4. There were clear flow charts in staff areas detailing the process to follow for safeguarding concerns for both adults and children.

Staff followed safe procedures for children visiting the ward. All children visiting the ward were accompanied by an adult at all times.

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.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

The service generally performed well for cleanliness. Monthly cleaning audits were carried out and results displayed on the medical ward and in the endoscopy department where an internal 5-star rating had been awarded for cleanliness in October 2023.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. There were clear cleaning schedules displayed on the ward and within the endoscopy department. These indicated the cleaning tasks, frequency and responsibilities. Staff signed to indicate that areas had been cleaned, for example, bathroom areas. We saw that bathrooms were cleaned several times a day and that cleaning staff could be contacted directly if problems were identified.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff using PPE correctly. An October 2023 audit of infection prevention and control (IPC) practices in endoscopy showed results of 91%. A hand hygiene audit was at 100%. Audit results for level 5 ward were 100% for both the IPC practices audit and the hand hygiene audit.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. There were daily and weekly cleaning schedules and an equipment cleaning flowchart to remind staff of the correct procedures for cleaning equipment. We viewed items of equipment including commodes, a hoist, bladder scanner and blood pressure cuffs. All were visibly clean and labelled appropriately.

Staff monitored patients for infections. It had been 351 days since the last hospital acquired infection within the medical service.

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.

Patients could reach call bells and staff responded quickly when called. Managers monitored how quickly staff responded to calls. We observed staff responding quickly.

Outstanding ☆

Medical care (Including older people's care)

The design of the environment followed national guidance. Patients on the level 5 medical ward were cared for in individual rooms with en-suite facilities. Rooms had sufficient space to provide care. We saw that environmental risks were identified and appropriately mitigated. For example, on the ward, risks associated with a hoist being stored in a corridor had been mitigated by removing one hoist to a storage area and ensuring the hoist in the corridor did not present an obstruction.

The endoscopy suite had a procedure room and three cubicles. These cubicles were spacious, with room for a bed. They were for patients to change before a procedure and recover afterwards. Cubicles were separated by partitions and curtains could be drawn across. There was access to a dedicated patient bathroom. The endoscopy suite was mixed sex due to the limited space available, however, risk assessments had been carried out and action taken to mitigate the associated risks. For example, patients requiring bowel preparation prior to a procedure had a bed booked on the ward before their procedure to ensure their privacy and dignity.

Arrangements were in place for the safe handling of endoscopes and their segregation, decontamination, and storage. We reviewed the process of decontamination from use to cleaning, decontamination, storage and saw there was good separation of clean and dirty instruments. Decontamination processes were in line with Health Technical Memorandum (HTM) 01-06 Management and decontamination of flexible endoscopes. There was a schedule for the servicing and maintenance of the endoscope decontamination equipment.

Staff carried out daily safety checks of specialist equipment. Resuscitation equipment was checked daily. We saw records of checks and viewed equipment and medicines on both the resuscitation and sepsis trolleys. Equipment was appropriately maintained, calibrated and portable appliance tested (PAT).

The service had enough suitable equipment to help them to safely care for patients. Staff checked equipment regularly and carried out monthly audits of medical devices. We checked equipment in endoscopy and on level 5 ward and saw that these were properly maintained. Medical devices audits for endoscopy and the ward showed 100% compliance for October 2023.

Staff disposed of clinical waste safely. Waste bins clearly signposted the different waste types.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. They used a recognised national early warning score (NEWS) to monitor and record physical observations such as blood pressure, respiratory rate and oxygen saturation levels. We reviewed patient records and found that the NEWS score was completed, calculated correctly and escalated where appropriate. Monthly audits of NEWS compliance were 100% on the medical ward. In addition, audit results showed that 100% of patients had a NEWS calculation on arrival. Patients who deteriorated could be cared for within the intensive therapy unit, or transferred to NHS services if that was required.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments were carried out on admission, for example, in relation to the assessment of pressure areas, nutritional status and the risk of falls. These were regularly reviewed and updated when changes occurred.

Staff knew about and dealt with any specific risk issues. There were clear procedures and escalations in place for specific issues such as sepsis. A sepsis trolley was located on the ward as part of the ward's emergency equipment, providing up to date national guidelines, equipment and medicines for actions to take when sepsis was suspected. Venous thromboembolism (VTE) where increased risk of developing blood clots in veins assessments were routinely carried out for all patients admitted to the ward. VTE prophylaxis (blood thinners) was prescribed as indicated from the assessment. Monthly audits of sepsis and VTE processes were conducted. The medical ward scored 98% for sepsis and 100% for VTE assessments in October 2023.

There was a clear inclusion / exclusion criteria in place. For example, the service did not provide care for patients suffering from acute cardiac conditions or stroke. The service did not provide care for patients with acute mental health issues. Where a patient required additional mental health support they were referred to their GP or in the event of an acute problem, to accident and emergency following an assessment by their consultant.

Staff shared key information to keep patients safe when handing over their care to others. Twice daily handovers were held at shift changes, that included both office and bedside handovers where information was shared about key care issues. Safety huddles were also held where staff would discuss any safety concerns or risks for specific patients, this included discussion of safety concerns such as unwell patients and risks such as falls and pressure sores. Other discussions included where patients had similar names and referrals to allied health professionals.

Shift changes and handovers included all necessary key information to keep patients safe.

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 service had enough nursing and support staff to keep patients safe. There was a basic nursing staff to patient ratio of 1 staff member to 3 patients. However, this could be increased when patient dependency increased, for example, if a patient required 1 to 1 care.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The planned staffing for each shift was a minimum of 2 registered nurses and 1 healthcare assistant. This was adjusted when there were fewer patients, with a minimum of 2 registered nurses on a shift irrespective of the number of patients. A staffing scheduling tool was used to plan and monitor staffing needs in line with any additional staffing needs as identified by senior clinical staff based on patient dependency. Staffing levels were reviewed throughout the day, including at morning and afternoon bed meetings to ensure there was an appropriate level of staffing based on patient need.

The ward manager could adjust staffing levels daily according to the needs of patients. For example, we saw that when there were fewer patients than the ward establishment, some staff would be transferred to other departments. Managers told us that staff moved from other departments if there were higher dependency patients on the medical ward. They gave us examples of where staffing numbers had increased in situations where patients were particularly unwell.

The number of nurses and healthcare assistants matched the planned numbers. We reviewed staff rosters and saw that the minimum staffing ratio was met.

Medical care (Including older people's care)

The service monitored vacancy rates. At the time of our inspection the vacancy rate for medicine was at 7.69%. This included a ward clerk post that had recently been recruited to and staff nurse post that was being advertised. The endoscopy department was staffed with an endoscopy manager and 2 registered nurses and a decontamination technician. In addition, the department used bank staff to ensure flexibility for busy times and emergencies. Staff we spoke with told us there were enough staff to operate the department safely.

The service monitored rates of bank and agency nurses used on the wards. Data provided showed that over the last 12 months bank use was at 2.6% and agency at 11.8%. Managers told us they used bank and agency to help them adapt to changing needs of the service and that some months were busier than others. Over the last 3 months the use of bank was 2.1% and agency 2.55%. Managers told us this reduced rate of agency staff was a reflection of the ward being less busy.

Managers limited their use of bank and agency staff and requested staff familiar with the service. They booked staff to work continuous shifts where possible.

Managers made sure all bank and agency staff had a full induction and understood the service.

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. There was 24-hour resident medical officer (RMO) cover on site. There were 2 RMOs on site at all times, 1 to cover critical care and another for general cover. The medical staff matched the planned number.

Consultants worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. The medical advisory committee (MAC) was responsible for approving practising privileges for medical staff, overseen by the medical director, relevant directorate manager and clinical director. Consultants with practising privileges and most had their appraisals and revalidation undertaken by their respective NHS trusts.

The service always had a consultant on call during evenings and weekends. All patients were admitted under the care of a consultant with practicing privileges. As part of this arrangement there was a requirement that all patients were reviewed by their consultant at least daily. There was 24 hour on call cover from a general medicine consultant. On call arrangements included telephone and face to face cover as needed.

Records

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

Patient notes were comprehensive, and all staff could access them easily. The service used a combination of paper and electronic records. We reviewed 6 sets of patient record on the level 5 medicine ward. We found that records were legible, signed, dated and up to date. Patient observations were recorded and completed at appropriate intervals. Risk assessments, management and discharge plans were appropriately documented.

In endoscopy, paper records included consent, an admission form, a standardised pre-procedure checklist, and procedure details and equipment used. Information was entered into the electronic record and paper records were then scanned onto the system.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. Staff completed information governance training. Paper records were stored securely in locked cabinets behind the nurses' station on the ward. Electronic records were secure, and password protected.

The quality of records was audited regularly. This included consent documentation with audit results between 96% and 98% for 2023. Audit results for medical consultant documentation were between 90% and 95%. Audit results for nursing record keeping was 94%. Audit results were presented at governance and quality meetings and actions agreed for improvement where necessary.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. There were regular pharmacy checks in place to ensure that medicines were prescribed safely. In addition, a local microbiologist monitored antibiotic prescribing within the department, reviewing patients prescribed antibiotics and contacting the prescribing consultant to discuss and review as necessary. This ensured that appropriate antimicrobial stewardship was in place so that antibiotics were not prescribed unnecessarily.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Pharmacists visited the ward daily to support medicine optimisation. They assisted with issues and ensured patients had the correct medicines prescribed and that monitoring was in place as appropriate.

Staff completed medicines records accurately and kept them up to date. We reviewed 6 prescription charts and saw that all were signed and dated, legible and that allergies were documented. There were no medicine omissions.

Staff stored and managed all medicines and prescribing documents safely. Medicines were secure. Keys to medicine cupboards were kept securely by nursing staff. Medicines were in date and there were comprehensive monitoring procedures in place, including regular checks of fridge and ambient air temperatures to ensure medicines were stored within the correct temperature range.

Staff learned from safety alerts and incidents to improve practice. Safety alerts were shared with departmental leads who took action to ensure relevant safety measures were taken. Safety alerts were reviewed as part of quarterly quality improvement meetings. We viewed 3 examples of medicine incidents and found that appropriate discussions about learning and improvement were held, and that full analysis of the root cause of the incident was conducted. One example included a prescribing error that led to an administration error. Immediate action was taken to reduce the risk of harm to the patient and staff reflected on the incident to identify specific actions to prevent a similar incident in the future. There was a clear process of learning and improvement.

Outstanding ☆

Medical care (Including older people's care)

Incidents

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

All staff knew what incidents to report and how to report them. There was a clear electronic reporting system and staff raised concerns and reported incidents and near misses in line with provider policy. There were 53 reported incidents within the medical service between November 2022 and October 2023. This included 2 near misses and the rest resulted in no or low harm to patients.

The service had no never events or serious incidents in the last 12 months. Records showed it had been 1591 days since the last incident that resulted in harm.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. We viewed example reports where there was evidence of open and honest discussions with patient when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. There was an open approach to sharing incidents. Those involved were asked to complete reflective statements as part of the investigation. Findings relating to incidents were then shared at a range of forums including governance meetings, staff meetings and safety huddles. Staff had the opportunity to be involved in discussions and learning.

Staff met to discuss the feedback and look at improvements to patient care. Shared learning summaries were produced for each incident and near miss, detailing the action taken, the identified root cause, learning outcomes and how learning was to be used to improve practice.

There was evidence that changes had been made as a result of feedback. For example, the implementation of drug chart checks during the handover process to support the identification of issues.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Is the service effective?

Good

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies were current and referenced relevant national guidance. This included National Institute for Health and Care excellence (NICE) and General Medical Council (GMC). For example, we saw that the service's consent policy had been updated to include the 2020 GMC '7 principles of decision making and consent'.

Medical care (Including older people's care)

NICE guidance was reviewed as part of the quarterly clinical operating group meetings. Newly published guidance was reviewed by a named service lead on behalf of the service provider. Guidance was then presented at the Quality Improvement Group (QIG) meetings, for discussions about adoption into corporate and service policies. Relevant policies and protocols were updated accordingly. National guidance was a standing agenda item at relevant governance meetings so that new guidance could be discussed and adopted into standard operating procedures as appropriate.

A series of quality assurance audits were carried out periodically, including some monthly audits. These audits included a check of compliance with relevant guidance. For example, in relation to do not attempt cardiopulmonary resuscitation (DNACPR) decision making and record keeping which was at 89% in October 2023.

The endoscopy department was not Joint Advisory Group (JAG) accredited. JAG accreditation signifies formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against agreed measures. The measures were against key areas such as the quality of patient experience, workforce, training and clinical quality. The environment the endoscopy service operated from made it difficult to meet the accreditation requirement, for example, around single sex accommodation. However, managers had undertaken a self-assessment of the service against the accreditation standards so that they were assured they were meeting as many of the standards as possible.

At handover meetings and daily huddles, 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. 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 had a wide range of food available to them during their stay. They were encouraged to make choices that appealed to them, and staff worked to meet specialist requirements. Patient satisfaction with the quality of the food offered to them ranged between 89% and 93% over a 12-month period between November 2022 and October 2023.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Records were appropriately maintained. Nutritional needs and care were evaluated as part of care planning review processes.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. All patients had an assessment of their nutritional status on admission and as part of their ongoing care.

Specialist support from staff such as dietitians was available for patients who needed it. Ward staff could refer patients to the dietician for specific advice and support.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. They used a numerical pain assessment tool, plus an adapted tool to assess pain through observation for patients unable to verbalise their pain. The service conducted quarterly audits of pain assessment processes. The most recent audit showed 96% compliance.

Outstanding ☆

Medical care (Including older people's care)

Patients received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately. Staff were quick to respond and evaluated the effectiveness of pain relief.

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.

Outcomes for patients were positive, consistent and met expectations, such as national standards. Data submitted to the Private Healthcare Information Network (PHIN) showed that fewer than 1 in 1000 patients had an unplanned transfer to another hospital and that 5 out of 1000 patients had a readmission within 31 days of discharge from the hospital.

Mortality and morbidity meetings were held monthly to review unexpected and expected deaths, unplanned transfers and unplanned readmissions within 7 days of discharge. There had been no unexpected deaths between November 2022 and October 2023.

Within the medicine department there had been 7 readmissions within 7 days between November 2022 and October 2023. Each was subject to a structured case judgement note review to identify learning and actions to improve the effectiveness of care and treatment and identify potential improvements to patient outcomes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. There was a programme of monthly and quarterly audits. These included clinical areas such as sepsis management, WHO (world health organisation) checklist completion in endoscopy, hand hygiene, medical devices and infection control. Results were consistently positive with areas such as sepsis management and the use of the WHO checklist achieving 100%.

Managers used information from the audits to improve care and treatment and they made sure staff understood information from the audits. Improvement plans were identified where audit results fell below the expected standards. Audit results were shared with staff and displayed on the ward and in endoscopy using the department governance board. Department managers worked with their team to implement improvements.

The service was accredited with exemplar status by the National Venous Thromboembolism (VTE) Exemplar Centre Network in August 2023. This accreditation provided recognition of the service's accomplishments in the prevention and care of VTE (where a blood clot forms in a vein).

Competent staff

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

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

Managers gave all new staff a full induction tailored to their role before they started work. We reviewed induction records and saw that staff had a comprehensive induction that included competency assessments that included the use of medical devices, medicines safety, blood transfusion and the safe use of medical gases. Staff told us they had a full induction that included time for training, shadowing and attending meetings.

Medical care (Including older people's care)

Managers supported staff to develop through yearly, constructive appraisals of their work. Data provided by the service showed that all nursing and medical staff eligible for an appraisal had received one in the last 12 months. The appraisal process included a mid and end of year review. The appraisal compliance for consultants with practising privileges was monitored and this included a 3-month grace period for appraisals to be completed before deactivation occurs. We saw that 1 consultant was in the 3-month grace period and all other consultants had received an appraisal through their designated body in the last 12 months.

Managers supported staff to develop through regular, constructive clinical supervision of their work. There were clear audit and feedback processes in place to promote learning and improvement. Managers made sure staff attended team meetings or had access to full notes when they could not attend.

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. Simulation training was held at the hospital for clinical staff. Examples included resuscitation, haemorrhage and anaphylaxis. Staff told us these were useful practical training sessions that helped them develop their confidence in dealing with unexpected clinical incidents.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. These involved input from members of the multidisciplinary team including medical and nursing staff, physiotherapists, pharmacists and a dietitian. Other specialist staff were available to be involved in multidisciplinary discussions as necessary, for example, the supportive and palliative care team when patients were at the end of life.

Staff worked across health care disciplines and with other agencies when required to care for patients. Patient care records showed that staff worked collaboratively with other agencies and professionals to ensure the delivery of coordinated care.

Patients had their care pathway reviewed by their consultant on a daily basis.

Seven-day services

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

Patients were admitted under the care of a named consultants who reviewed their patients at least daily. A resident medical officer (RMO) was available on site 24 hours a day, 7 days a week. In addition, there was 7-day access to diagnostic imaging and other tests, including through an out of hours provision.

Pharmacy services were accessible 7 days a week, including an on-call pharmacist outside of normal working hours.

Health promotion

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

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

Outstanding ☆

Medical care (Including older people's care)

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

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 measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. There were clear policies and guidance for staff to follow, including flow charts reminding them of processes displayed in staff areas.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff described where a mental capacity assessment had been undertaken which determined a patient lacked capacity to make decisions about where they received care. A deprivation of liberty safeguard application was submitted to the local authority and appropriately withdrawn when the patient was discharged.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Consent processes were comprehensive and there were appropriate checks in place. For example, within the endoscopy department the safety check list included a check that consent had been sought and appropriately recorded. In addition, the endoscopy manager told us that the nurses had conversations with patients in addition to the consultant to ensure that relevant information was understood, and that consent was given only when patients were sufficiently informed of the procedure. Staff clearly recorded consent in the patients' records.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. There were clear procedures in place to ensure that decisions were made in the patient's best interests with input from the patient's representatives or an independent advocate as needed.

Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Training compliance data showed that 100% of staff within the medicine department had completed and were up to date with Mental Capacity Act and Deprivation of Liberty Safeguards training.

Is the service caring?

Outstanding ☆

Our rating of caring improved. We rated it as outstanding.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Survey results showed that patients consistently felt they were treated with dignity and respect.

Outstanding ☆

Medical care (Including older people's care)

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed nursing and allied health professionals interacting with patients with dignity and respect. Hospital inpatient and endoscopy survey results for 2022-23 showed positive results of 99-100% for patients feeling they were treated with dignity and respect by staff.

Patients said staff treated them well and with kindness. Patients we spoke with told us they were happy with the care they received, and that staff were supportive and kind.

Staff followed policy to keep patient care and treatment confidential. Patient consultations and care on the medical ward were delivered in private rooms where confidentiality was assured. Staff handovers and discussions were held discretely.

Within the endoscopy department recovery bays were partitioned and curtains were used to provide privacy. Patients receiving pre-procedure bowel preparation were offered a private room on a ward to ensure their dignity was preserved. Staff worked hard to ensure patient's privacy and dignity was maintained.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patient assessments were holistic, and staff understood cultural, social and religious needs and how this impacted on patient's experience of care.

Emotional support

Staff provided strong emotional support to patients, families, and carers to minimise their distress. They understood patients' personal, cultural, and religious needs and made sure this was reflected in how care was delivered.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff told us they had time to provide emotional support and advice as needed. Patient survey results showed that between August and October 2023 an average of 98% of patients stated they were able to talk to staff about their worries and fears.

Staff demonstrated empathy when interacting 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. We observed staff interacting with patients in a way that demonstrated these skills.

Patients had access to spiritual support through the hospital chaplaincy team. Patients could access psychological support services as needed during admission. Staff followed patients up following discharge home to ensure their needs were met and to check if there were any further support needs.

Understanding and involvement of patients and those close to them

Staff were fully committed to supporting patients, families, and carers to understand their condition and empower decisions about their care and treatment. Consideration of people's needs was consistent and there was evidence that staff went above and beyond what was expected in ensuring patients were involved and supported.

Staff made sure patients and those close to them understood their care and treatment. The nurse in charge visited each patient every day to check how they were and if they were receiving good care and support. This provided patients with an additional opportunity to raise concerns and discuss their treatment and care. Survey results showed that 92% of patients felt they were involved in decisions about their care as much as they wanted to be.

Outstanding ☆

Medical care (Including older people's care)

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Survey results showed that 100% of patients received answers to their questions in a way that they understood.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients were asked to complete surveys following their admission or procedure. Patients gave positive feedback about the service. Patient experience results displayed within the ward showed that 98% of patients would recommend the service to their family and friends. Within endoscopy 100% of patients described their experience as very good.

There was a 'you said, we did' board describing action taken in response to patient feedback. One example was feedback from a long-term patient on the medical ward who was finding the menu repetitive. Staff arranged from them to meet with the catering manager and chef who made personalised changes to the menu for the patient. As a result of this the catering team implemented meeting with any patient who had been an inpatient for a week or more to provide a more tailored approach to menu planning.

We viewed written feedback from patients that described the support they received from staff. This included a patient who stated staff made them feel 'like I was the most important patient in the building.' A relative described the care for their loved one as 'impeccable', another referenced the 'compassion and dignity' shown.

Is the service responsive?

Good

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

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

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

Managers planned and organised services, so they met the changing needs of the local population. They had a clear inclusion and exclusion criteria for the medicine service. Exclusions included treating patients under 18 years old, those requiring treatment for Covid-19, pregnancy related problems, those requiring acute mental health intervention, acute stroke and acute myocardial infarction (heart attack). The criteria was regularly reviewed and updated.

They had an acute medicines unplanned admissions review group who provided governance oversight of acute unplanned services to monitor and improve the services. They reviewed activity on a monthly basis so that the services were safe and effective and met the needs of patients.

Facilities and premises were appropriate for the services being delivered. Patients were cared for in individual en-suite rooms. There were appropriate facilities to care for patients appropriately. This included moving and handling equipment and step free access to patient areas.

Staff could access emergency mental health support 24 hours a day seven days a week for patients with mental health problems. They could contact on call psychiatrists to support them.

The service had systems to help care for patients in need of additional support or specialist intervention.

Outstanding ☆

Medical care (Including older people's care)

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 provided inpatient care for patients with a range of conditions requiring medical care and support. Staff made sure patients, including those living with additional needs, for example, learning disabilities and dementia, received the necessary care to meet all their needs. Staff had received training in dementia, learning disabilities and autism.

Wards were designed to meet the needs of patients living with dementia. A dementia quality improvement project had been implemented with the aim of improving the patient pathway and support carers and family in the community. The project involved a range of staff working together to follow best practice and implement agreed changes. Actions included implementing dementia friendly signage, the use of a visual menu, and dementia friendly crockery and cutlery. We saw picture prompts available for use when communicating with patients with dementia, this included pictures to help patients make meal choices.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. There was 100% compliance on the completion of learning disability and autism training.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. For example, hearing loops were available, and staff had access to visual prompts to aid communication with patients with dementia or memory loss.

The service had information leaflets available in languages spoken by the patients and local community. We saw a range of information that included different language options to meet the information needs of patients and the local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. They had access to telephone and online interpreting services.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Chefs prepared meals to suit individual needs and wishes. Patients could request foods they wanted. There were a range of menus available providing food choices to meet individual needs. This included Kosher and Halal meals. Menus were available in different languages.

Staff had access to communication aids to help patients become partners in their care and treatment.

There was a multi-faith room available on the ward. The room had neutral decor with prayer mats and different faith publications.

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.

Outstanding ☆

Medical care (Including older people's care)

Managers made sure patients could access services when needed and received treatment within agreed timeframes and targets. There were no waiting times for patients to access the service. The service had an unplanned admission pathway with key performance indicators in relation to how quickly patients were seen. In 2023 to date 310 patients had been admitted through the unplanned admission pathway.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and targets. We reviewed admission data for September 2023 and saw that 47% of admissions were for general medical treatment and care. We found that 100% of patients received a consultant review within 14 hours of admission. There had been no readmissions within 7 days during September.

Overall data for the current year showed there had been 7 readmissions within 7 days for medical patients. Managers and staff worked to make sure patients did not stay longer than they needed to. The average mean length of stay for medical patients was 3.93 days.

The service moved patients only when there was a clear medical reason or in their best interest. Staff did not move patients between wards at night.

Managers and staff started planning each patient's discharge as early as possible. A discharge checklist was completed as part of the discharge planning. This included prompts to ensure relevant referrals and reviews by members of the multidisciplinary team had been completed and that medicines to take home had been received and explained to the patient.

Staff supported patients when they were referred or transferred between services. Transfers were reviewed and discussed as part of clinical governance processes to ensure that decisions were appropriate, and learning was shared.

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. A patient guide was available, providing information on how to complain. Patients were given information on how to make informal and formal complaints and what to expect from the process, including planned response times. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Ward managers visited each patient daily as part of their 'rounding' process to check if they were satisfied with the service. This gave patients the opportunity to raise concerns and managers worked to resolve them before they became a complaint.

There were processes for managers to investigate complaints and identify themes. However, there had only been one complaint relating to medical services in the last year.

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

Outstanding ☆

Medical care (Including older people's care)

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, we saw learning outcomes from an investigation included training refreshers and reminders to staff about rounding and communication processes.

Staff could give examples of how they used patient feedback to improve daily practice. Feedback reports were included in discussions at governance and staff meetings. This gave staff an opportunity to be involved in taking action to improve.

The service was a member of ISCAS (the Independent Sector Complaints Adjudication Service) and could refer complaints to ISCAS in the event of internal resolution not being reached.

Is the service well-led?

Outstanding ☆

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

Leadership

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

There was a clear management structure with defined lines of responsibility and accountability. The executive team was led by a chief executive officer with support from a chief operating officer, a medical director, a chief nurse, a chief HR officer and a chief finance officer. The deputy chief nurse line managed acute medicine and unplanned admissions, as well as the allied healthcare professionals' team.

Leaders at all levels showed a high level of experience, motivation and capability to deliver sustainable care. They demonstrated an understanding of priorities and issues. This included priorities such as improving 'do not attempt cardiopulmonary resuscitation' (DNACPR) reviews, as well as ongoing operational priorities such as upgrading the electronic patient record system.

Staff spoke highly of their managers and service leads. They told us managers were visible on the ward and in endoscopy. They were approachable and friendly, and staff knew who the senior leadership team were and had the opportunity to speak with them. Senior leaders regularly visited the ward. The 'walk in your world' programme saw senior leaders working alongside staff in clinical areas. In addition, senior staff undertook daily 'rounding' where they would speak with colleagues and patients to understand their experiences. Staff told us they felt supported and enjoyed working with their colleagues and managers.

Staff told us they felt supported to develop their skills and take on more senior roles. For example, we saw that opportunities for development were discussed as part of the six-monthly appraisal process. There were clear succession plans in place and a culture of investing in staff to help them develop their skills and seek promotion. Staff were supported in their relevant studies and were helped to develop into more senior roles. There were examples of staff promotions throughout the service, including staff nurses moving into ward sister roles.

Outstanding ☆

Medical care (Including older people's care)

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.

There was a clear mission with a commitment to the care and improvement of human life and an 'exceptional people, exceptional care' vision. Values of 'unique and individual', 'compassion and kindness', 'honesty, integrity, fairness' and, 'loyalty, respect and dignity'. Staff we spoke with understood the mission, vision and values. Staff were able to articulate how the service values were integrated into care activities. We saw that care was individual and that staff communicated with compassion and kindness.

The strategy had a clear focus on patient outcomes, patient experience, people, growth and finance. Growth plans included increasing referrals from GPs, including HCA Healthcare run private GP practices. We saw examples of improvements in endoscopy as part of the growth strategy, with the upgrade of equipment and work towards increasing activity.

Strategic development and how it impacted on the sustainability of services was discussed at relevant governance meetings. For example, priorities were reviewed as part of the medical advisory committee (MAC) meetings and progress was monitored.

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 told us they were well supported by leaders and felt respected and valued. There was a clear ethos and focus on the needs of patients and those close to them. There were staff wellbeing resources embedded within the service. These include support to manage stress, wellbeing webinars and an employee assistance programme. They also had free access to wellbeing apps and there were 2 mental health first aiders based at the hospital, as well as others across HCA Healthcare. Access included weekly drop-ins where mental health first aiders were available to listen and support staff.

There was a range of staff recognition systems. These included the employee of the quarter and the colleague of the year awards where staff were nominated by their colleagues in recognition of their efforts. Daisy awards were for patients and those close to them to recognise how individual clinical staff impacted on their care. Bee awards were for patients and those close to them to recognise non-clinical staff and their contribution.

Staff told us they were treated as individuals, and they felt empowered to safely care for patients. There were nominated 'speak up' champions who staff could approach should they not feel comfortable speaking with their line manager about concerns. There were 'speak up' posters reminding staff of who the champions were. Staff, patients and families were encouraged to provide feedback and raise concerns without fear of reprisal. They told us there was an open and honest culture and they felt they could raise concerns without fear of blame. We observed a range of processes that supported an open and honest culture. This included a transparency around incidents, audit findings and areas where improvements were needed.

Outstanding ☆

Medical care (Including older people's care)

The service promoted equality and diversity in the daily work. The provider had a diversity, equality, inclusion and belonging (DEIB) strategy which focused on inclusive and accountable leaders that embraced DEIB. A diversity and inclusion group made up of representatives from different staff groups, nationalities and cultures worked together to raise awareness and increase understanding by celebrating different religious and cultural days and other activities.

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 service had clearly defined and embedded governance processes in operation. Staff were clear about their roles and responsibilities and understood procedures to escalate issues. Staff at all levels were actively involved in governance processes and were able to articulate established processes.

The senior leadership team had overall responsibility for governance through the Lister quality and safety board that was interlinked with the HCA Healthcare quality and safety board. Various sub-committees and reporting structures focused on specific areas including hospital governance; medical governance; nursing, surgical and AHP; health and safety and estates; and medicines.

The service produced a quarterly clinical operating report (QCOR) and monthly clinical operating report (MCOR). The report was used to monitor and review patient safety and risk, clinical effectiveness, patient experience, regulation and sustainability through the quarterly clinical operating report meetings.

The morbidity and mortality group met monthly and reported into the quality and safety board. The group reviewed areas such as mortality, unplanned transfers and unplanned admissions across the hospital and identified any learning to be shared. These meetings involved consultants presenting cases for learning and review.

The medical advisory committee (MAC) met quarterly and reviewed clinical quality and governance matters including risks, incidents, new services, patient experience, research and practicing privileges. A lead for each medical specialty was represented on the (MAC) to consider applications for practising privileges, which were regularly reviewed. Systems were in place to ensure there were no conflicts of interest for consultants who had practising privileges and that appraisals and training were up to date.

An incident review group (IRG) reviewed actions and decision making for open and overdue incidents, following an agreed reporting and completion timeline for investigations and actions to be completed.

A quality and improvement group met monthly with representatives from across the hospital to review audits, quality improvement projects, safety alerts, policies and training.

Governance boards were displayed on the ward and in the endoscopy department. These included performance information about specific measures.

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.

There was a thorough audit programme with clearly planned repeat audit cycles. Audit results were published at regular intervals, including monthly for some audits such as medical device checks, infection control, hand hygiene, health and safety and emergency equipment checks. Performance was reviewed at governance meetings and there was a clear approach to audit and performance management of the service.

Nursing performance review (NPR) exception reports were completed, highlighting exceptions to areas of quality audits where 100% compliance was not achieved. In addition, the NPR included other aspects of performance such as incidents, staffing issues, transfers and readmissions. It was completed for each clinical area and ward to highlight exceptions and actions to address these. Exceptions were highlighted as part of the clinical operating report.

Leaders also identified risks from risk assessments and safety alerts, staff and patient feedback, incidents and complaints. Reporting processes were clear, and staff understood the need for accurate and up to date reporting of issues and concerns so that risks could be properly managed and mitigated.

Leaders in the medical service were able to describe risks associated with their department. Risks were recorded, discussed and mitigations put in place at regular meetings. Risks that scored moderate or above were included in the hospital wide risk register which was overseen by the senior leadership team. The risks staff described to us reflected the risks identified on the risk register. There were 2 moderate risks relating to moving and handling equipment stored in a corridor on the ward and a lack of fire doors in the corridor between 2 rooms. Mitigating actions were taken to ensure that equipment did not obstruct fire doors or the main walkway. We were told that funding had been sourced to install new fire doors between the 2 rooms on the medical ward. However, there was no project start date. Mitigating actions included that only patients who were fully mobile should use the identified rooms. These rooms were not in use at the time of our inspection.

The service had clear business continuity plans for unexpected or emergency incidents such as power loss or fire. Staff knew how to access protocols and guidance and understood how to escalate concerns through on-call or emergency services as needed.

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.

Staff had access to patients' health records and the results of investigations and tests were available in a timely manner. There were plans to establish a fully electronic record system in 2024.

The service used electronic systems which allowed the service to manage quality and compliance processes and ensure audit completion. This included electronic incident reporting and audit activities. Data from these activities was collated and reported on a monthly basis. Information was published internally in a variety of formats and reporting templates. These included governance boards in clinical areas and data reports for governance meetings. This meant that performance was evaluated promptly, and information was accessible so that decisions and improvements could be timely.

There were effective arrangements to ensure the confidentiality of patient identifiable data. Paper based patient records were stored securely in lockable cupboards at the nurse's station and electronic information was on a secure server. We observed staff maintaining the confidentiality of both electronic and paper records. Staff were able to access information such as policies, training and information updates through electronic systems. There were sufficient computer stations on the ward and staff told us the system worked well. The service submitted statutory notifications to the CQC as required.

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, staff and patients to help improve services.

All patients were asked to complete a feedback form as part of their discharge planning. Feedback results were displayed on wards and in endoscopy. Staff were encouraged to participate in discussions about patient feedback and contribute to suggestions to make improvements as necessary. Following discharge patients were contacted by specialist nurses to check if their discharge had gone well or if they had any needs.

There was a patient forum, and all patients were invited to attend. Improvements because of patient feedback included adding a braille system to the hospital lifts. Meeting dates were planned in advance for every quarter and all patients received emails inviting them to attend and share their experiences so these could be used to improve and develop the services. 'You said, we did' boards displayed action taken to improve as a result of patient feedback. Patients were actively encouraged to feedback through daily 'rounding' by senior clinical staff who met with all inpatients to discuss their care and their needs.

There were clear staff engagement processes within the service. These included breakfast meetings for new staff with the chief nursing officer, a social and engagement committee to create a positive and productive workplace culture, and a diversity and inclusion group. In addition, there were bi-monthly 'talk back' sessions hosted by the senior leadership team where staff could share their thoughts and ideas.

A staff survey was conducted and results for the medical service showed the top strengths were identified as training, accountability and collaboration. Communication, belonging and recognition were areas where actions were being taken. These included launching a monthly employee council, team days, link nurse involvement in quality improvement projects and encouraging staff to use the colleague recognition process. Staff we spoke with told us they felt happy in their work and were positive about the opportunities available to them, including their involvement in quality improvement.

There was a diversity and inclusion group where there was representation from 12 different nationalities. The aims of the group included to increase understanding of different cultures and understand how cultural differences can influence behaviour.

Staff were encouraged to get involved in the wider service development. For example, there was a professional practice council with representation from nurses and allied health professionals (AHPs) working in all areas of the service. The aim was to give nurses and AHP's a strong professional voice in improving clinical outcomes, patient experience, efficiency delivery, physician confidence and workforce engagement.

Outstanding ☆

Medical care (Including older people's care)

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.

Processes for learning and continuous improvement were embedded within the service. Improvement methodologies such as audit were used on an ongoing basis to identify and evaluate improvements. Staff at all levels were involved in improvement and regular discussions about learning were held during staff meetings and daily huddles on the ward.

Within endoscopy investments and improvements had been made to the quality of the equipment to improve the quality of images and comfort for the patients. The endoscopic device utilised artificial intelligence and helped to identify abnormalities as early as possible and a thinner tube made the experience more comfortable for patients.

The Lister Hospital Professional Practice Council (PPC) was set up to mobilise and organise nurses and AHP's to consistently deliver the highest standards of professionalism, pride, and practice. The PPC had a key role in shaping the Lister professional agenda to improve clinical standards through quality improvement and enhance patients' experience. It aimed to engage staff at all levels in quality improvement. An example of work led by the PPC was the development of an HCA Healthcare wide dementia care pathway for use across all HCA services. Staff working in medicine within the Lister had been involved in its development. The pathway provided a clear framework for delivering care to patients with dementia in line with national guidance.

A falls prevention quality improvement research project was being led by one of the physiotherapists as part of their master's degree. There was a focus on preventing falls and exploring the multifaceted nature of them, including exploring why patients fall. An example of action relating to this included the production of a falls leaflet for younger patients where it was identified that falls were occurring due to a lack of understanding of how their admission may impact their usual level of mobility.

The service had been awarded exemplar status in August 2023 by the VTE Exemplar Network for their commitment to promotion of best practice and prevention of venous thromboembolism (VTE). VTE champions had been identified in all clinical areas of the hospital, led by the VTE clinical lead as part of the service's VTE strategy.

Good

Outpatients

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

Is the service safe?

Good

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

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. Staff were encouraged to check their learning profiles every week. The learning academy portal allowed each member of staff to view compliance with mandatory training modules via an easily identifiable colour system (green – up to date, amber – about to expire – red – expired). Monthly reports were sent by the learning academy to managers of staff detailing their compliance with mandatory training.

The online training system was described to be quite intuitive, as the system was good at identifying when a member of staff was a month away from becoming non-compliant with their training. It would also give a 4-month warning for training like immediate life support (ILS) training, which required staff to book onto a face to face course. We were informed that some staff who were booked on the ILS training but hadn't yet attended, showed up as amber in the training system.

Mandatory training was comprehensive and met the needs of patients and staff. Mandatory training modules for nursing staff working in the service were aligned to the 'Core Skills for Health Training Framework' (CSTF). The CSTF set out 11 statutory and mandatory training topics for all staff working in health and social care settings. The CSTF included nationally agreed learning outcomes and training delivery standards. Modules that nurses completed included but were not limited to were: infection control and sepsis; Moving and Handling, Health and Safety; Mental Capacity Act and the Deprivation of Liberty Safeguards Training; and The Oliver McGowan Mandatory Training on Learning Disability and Autism Level 1.

Mandatory training modules for substantive consultants and consultants employed under practising privileges fell under training categories which included: resuscitation, ethics, safeguarding, radiation protection, and core skills. Under the 'core skills' category, training modules included but were not limited to: Health & Safety; Infection and Control, Working Safely at HCA, Patient Manual Handling; and Information Governance.

The hospital accepted consultants' training transcripts from other external acute hospital providers and would honour the frequency of completion as set out within their learner's assessment record at their acute hospital.

Managers monitored mandatory training and alerted staff when they needed to update their training. Mandatory training was scrutinised closely and was discussed at the clinical leaders meeting. The head of outpatients had oversight of mandatory training for the entire outpatients team. They held a manager profile on the online training system so they could view each member of the team's training matrix to see who was compliant and not.

The Learning Academy for the organisation produced a report twice monthly for all teams and departments, and this was another way in which the head of the service could ensure overall compliance with staff members' training. These reports were available to all managers.

The majority of mandatory training was completed online but there were some face-to-face modules that had to be completed in a classroom environment. Certain training modules were designated as mandatory for specific roles within the outpatients service. Compliance with these mandatory training modules were closely monitored and staff members were required to complete these sessions within specified timeframes. Individual staff members' training records and compliance were held on the training system. Sisters in charge of each outpatient clinic area were responsible for monitoring training compliance. They were responsible for ensuring that their team members were up to date with their training requirements and for addressing any barriers to compliance. Reminders around mandatory training compliance were given in monthly department meetings.

In cases of non-compliance with mandatory training, managers would seek to understand the barriers preventing staff from completing their training. Solutions included offering additional training sessions, providing time during work hours for training, or addressing any technical issues with online training platforms.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Medical staff who worked for separate organisations who provided care through practicing privileges maintained the same standard of training as substantive staff.

There were no safeguarding issues reported in the previous 12 months. There were also no female genital mutilation (FGM) issues reported, but staff we spoke with were able to demonstrate how to escalate safeguarding concerns.

We saw an updated safeguarding adult's escalation flowchart in the staff waiting area, which listed the immediate steps staff needed to take if they had any concerns about any adult patients using the service. The flowchart provided contact details for who the hospital and corporate safeguarding leads were. The flowchart underscored the importance for staff with concerns to discuss with relevant staff members and the safeguarding lead, to consider whether the adult at risk may not be able to protect themselves, and to record concerns in the patient's health record. The safeguarding flowchart was an addition to a more formal safeguarding policy that the hospital held.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The safeguarding lead for the hospital was the Chief Nursing Officer.

Good

Outpatients

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.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. The organisation's commitment to cleanliness and keeping the hospital clean formed part of the infection prevention and control strategy. The hospital's cleanliness charter pledged to: provide a well maintained, clean and safe environment to reduce the risk of healthcare associated infection, using the most up to date cleaning methods and frequencies; maintain a strong housekeeping team with clear leadership that encouraged a cleanliness culture across the whole organisation; and to involve patients and visitors in the cleanliness and infection prevention control agenda by providing good clear information.

The service generally performed well for cleanliness. The outpatients area on the second floor of the hospital building had been audited on the 14 November 2023 and achieved a five star cleanliness rating. The audit was to be repeated again on the 31 January 2024.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We observed a cleaning checklist in one of the patient toilets in the waiting areas. The toilet was fully stocked with hand towels and hand washing consumables. Hand sanitiser was also available outside of the toilets.

Cleaning dates and times were 11:30pm – 7:30am Sunday to Thursday and on request between 8am and 10pm Monday to Friday. Housekeepers were responsible for most cleaning tasks such as the cleaning of toilets, urinals, sinks and taps; windows; floors (including skirting); walls and ceilings. The scope for cleaning was to damp wipe surface areas using a disposable cloth with detergent/disinfectant and then to mop flooring areas using a detergent/disinfectant and dispose the mop head at the end of the clean. Nursing and clinical staff were responsible for the cleaning of medical equipment.

Staff followed infection control principles including the use of personal protective equipment (PPE). Consultation rooms had wash basins in each room. PPE stations were stocked with gloves and aprons. The hospital followed a national cleaning colour coded scheme as per the national patient safety agency guidelines.

We sat in on a patient consultations where they had visited the service to have their dressing replaced. Good hand hygiene was observed both by the consultant and the clinical nurse specialist. PPE was used appropriately, and all clinical waste was disposed of correctly.

Fresh gowns were kept in a cupboard within consultation rooms and used gowns were placed into a bin designated for linens. We saw evidence of disposable curtains that had recently been changed.

There was a 'Make infection prevention your intention' infographic poster visible in the clinic areas. The poster was designed to give advice and support for patients on how they can help prevent infection. The infographic poster covered topics such as hand hygiene, respiratory hygiene and staying hydrated.

There were signs at the entrance of clinical areas stating that staff had to be bare below the elbows. There was also '5 moments to hand hygiene' posters above wash basins.

There had been no reported cases of Clostridioides difficile (C. diff), Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive Staphylococcus aureus (MSSA), Covid-19, or any other infectious diseases within the department between November 2022 to October 2023.

Staff received ongoing training in infection control practices. This training was updated regularly to reflect the latest guidelines and best practices, and was monitored by the hospital's infection, prevention and control (IPC) team and head of department. The department maintained an effective communication channel with the hospital's IPC team (including microbiologist). This ensured that any potential risks were reported and addressed promptly.

We observed a visitor to the hospital inform the front of house team about dog foul on the steps leading into the building. We then observed a member from the front of house team promptly get housekeeping to quickly resolve the issue by cleaning the area.

Environment and equipment

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

The design of the environment followed national guidance. The Argyle outpatients clinic area had 6 consultation rooms and the Chester outpatients clinic area had four, with one colposcopy room. The colposcopy room was air conditioned and the temperature was checked daily. Consultation rooms had extremely wide doors and monitors did not face patients.

Staff carried out daily safety checks of specialist equipment. The resuscitation trollies were located in the corridors of the clinic areas near the reception. The defibrillator battery was checked weekly, and records were seen for this. Daily trolley checks were completed and there were records to support this. We opened the draws of a resuscitation trolley and checked the contents of each drawer. Drawers were clean and sufficiently stocked, with all expiry dates highlighted; items expiring soon were noted. All nursing staff were responsible for daily checks.

The service had enough suitable equipment to help them to safely care for patients. All equipment had been portable appliance tested (PAT) tested. We looked at the PAT testing for: x3 examination lights, x1 blood pressure monitor, and x3 computers, which were all in date. PAT testing was undertaken by the medical physics department and records were held by them. This was undertaken on an appropriate date. Equipment with servicing contracts, were managed by the respective manufacturing companies.

At the time of our inspection, a urinalysis machine had received a PAT tested previously but was not currently working, as the department were awaiting a part to be delivered for the machine.

The biomedical department looked after the hospital's biomedical equipment for all facilities. There was a medical devices meeting that took place once a month. This meeting was chaired by the Chief Nursing Officer (CNO) but updates within the meeting were predominantly given by the biomedical department.

The central sterile supply department was rarely used as most equipment was single use, however decontamination was completed on site if needed.

Storage cupboards contained stock lists. Staff were responsible for checking stock levels and re-ordering. All single use items had expiry dates highlighted. Several stock items were checked and were all in date.

Staff disposed of clinical waste safely. Waste bins were colour coded to clearly identify for domestic waste, hazardous waste and clinical waste. Clinical waste was removed by cleaners overnight. Sharps bins were dated and not overfilled. Cytotoxic sharps bin were available if required. There were also floor standing sharps bin on wheels, which were appropriately dated.

There was a locked control of substances hazardous to health (COSHH) cabinet stored in a cupboard under the sink.

There was a fridge located in the treatment room, which was locked. Fridge and room temperatures were checked, documented and logs kept for record keeping purposes.

In the event of a fire or need for evacuation, the fire assembly point was a short walk left out of the main hospital building.

Assessing and responding to patient risk

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

There was no Accident and Emergency department at this hospital and we saw signs outside of the hospital building advising members of the public of this.

The department had a deteriorating patient policy. Deteriorating patients were kept in the department and observations were carried out. A Resident Medical Officer (RMO) would be called if necessary and the hospital crash team were available for cardiac arrests. The head of outpatients told us that the department had previously had patients faint in the department but nothing more serious than that.

The department had a pathway for the management of a deteriorating individual without established funding status. The process followed that if a visitor presented with a life threatening condition then a London based ambulance service was contacted as well as the hospital's crash team. Treatment and escalation would occur as clinically indicated whilst awaiting the ambulance. A situation background assessment recommendations (SBAR) handover would occur until the individual was transferred. A duty manager or person in charge would then complete an incident report and would immediately notify the patient access manager.

Patients known to faint after blood tests or those fasting before blood tests would be asked to lie down straight away and raise their legs. Episodes of fainting in the department were generally dealt with by the nursing team in the department.

The hospital had resuscitation meetings, which was chaired by the resuscitation lead for the hospital, who was also the clinical practice facilitator. A designated supervisor from an external training company who would deliver immediate life support training for staff, also attended the meeting. They contributed to the meetings by leading on risks and simulations, and updating staff on any changes in resuscitation guidelines.

There was a sepsis six poster from The UK Sepsis Trust on the staff notice board, which listed the six medical therapies to reduce mortality in patients with sepsis. Staff knew how to recognise signs of sepsis.

Patients were no longer required to wear a face mask when visiting the service but were advised not to attend the service if they had covid-19 or any other respiratory symptoms. Masks were still available if patients wanted to wear one.

There was 100% compliance with health and safety training for all staff working in the department.

Good

Outpatients

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 department under the Lister Hospital CQC registration constituted of 4 different locations, namely The Lister Hospital; Nine Elms and Battersea; Sydney Street, and 272 Kings Road – outpatient physiotherapy service. The head of outpatients oversaw each of the four locations. There were no outpatients clinics that took place at Nine Elms and Battersea and Sydney Street on the day of our inspection.

There were 5.8 full time equivalent (FTE) staff working at The Lister Hospital but there was a vacancy for a deputy outpatients manager. For the outpatients department at The Lister Hospital, there was a sister-in charge, two senior staff nurses, and two staff nurses.

There had been one vacant sister post at the Nine Elms and Battersea clinic location, but the post had since been appointed to and the new starter had a start date February 2024. Nine Elms and Battersea had 3 FTE staff.

102 Sydney Street had 9 FTE staff and two vacant posts, which included a staff nurse post and a healthcare assistant (HCA) post. An interview was scheduled to take place for the HCA role and an appointment for the staff nurse had since been made.

There were no vacancies at the outpatient physiotherapy clinic at 272 Kings Road; there were 2 FTE staff working there.

On the days of the week that the department were busy, the service would utilise the provision of bank and bureau staff (a pool of staff that are permanently employed by the organisation. They were contracted to work a set number of days or hours for the week but had flexibility to work across all the HCA sites). Bureau staff could choose the days and times they wanted to work, however they had to work in departments that had staffing needs.

The hospital had a strong pool of bank nurses who regularly worked in the department, and would be used to cover shifts where substantive staff were on study leave, emergency leave, sick leave etc.

Grading structures for nursing were specific to the hospital and were not aligned with the NHS banding. The organisation strived to align with NHS banding in terms of roles and responsibilities, but the organisation had more flexibility using their own grading structure.

At 1:30PM, there was a workforce planning meeting which was held daily. In this meeting, clinics and staffing across all of the outpatients facilities were discussed. We were informed that there was good cross-site cover when needed.

There were 449 consultants working in the hospital who held practising privileges. Of those 449, 231 of them worked within the outpatients departments.

Records

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

Patient notes were comprehensive, and all staff could access them easily. The hospital used an electronic patient record system to capture patient's episodes of care. Registration forms were completed online by the patient before their appointment, or completed when arriving at the department, which would then be scanned onto the system. Other forms that were scanned in, included pathology and blood forms.

Before any patient transfer, staff conducted a thorough assessment (including vital signs) to determine the patient's current condition and specific needs during transfer. This included reviewing the patient's medical history, current medications, recent treatments, and any special requirements they may have and all pertinent patient information was documented on the patient's electronic patient record.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. Some medical records held by consultants were brought with them to clinic and removed at the end of the day and transferred by couriers to the various HCA sites that the consultant worked at; this was arranged by their secretaries. We were informed that most consultants working in the department used the electronic patient records system but there was a minority of consultants who still kept paper notes.

Confidential paper waste could be left in an in-tray to be collected or could alternatively be handed to a nurse. The in-tray was located behind the consultants' desks.

100% of staff working in the department had completed information governance training.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Private prescription pads were held in a locked cupboard. A tracker sheet was completed when medicines were prescribed.

Staff stored and managed all medicines and prescribing documents safely. Medicines were kept in a locked medicines cabinet and were topped up weekly by the pharmacy department. The outpatients department did not store controlled drugs and all drugs that we looked at were all in date.

Medicine management audits for the outpatients department comprised of the 'Safe and Secure Medication Storage' audit and had received 100% compliance in the preceding 12 months. Medicines management audits were conducted independently by a member of The Lister Hospital pharmacy team on a quarterly basis, in keeping with the organisation's corporate audit schedule. Results were reviewed immediately by the team and further disseminated through the Medication Management Committee and facility level Quality Improvement Group led by the local governance team. Specific, measurable, achievable, realistic, and timely (SMART) action plans were developed against any noted areas of non-compliance, in conjunction between the pharmacy and outpatient team to ensure oversight, improvement and on-going compliance.

The pharmacy opening hours were Monday to Friday: 9am to 5pm and Saturday: 9am to 1pm

Good

Outpatients

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. The department had a good incident reporting mechanism, which all staff were trained to use. Staff received feedback on incidents via staff meetings which were held monthly. Minutes from the meetings were cascaded to all staff.

The service had no never events in the last 12 months. The outpatient department had not reported any incidents that qualified as "never events". To maintain the highest standards of patient care and safety, the department implemented comprehensive protocols and regular training sessions to ensure that all staff members were well-versed in the latest safety procedures and guidelines, to prevent any never events in the department.

In the last 12 months the outpatient department did not report any incidents classified as serious.

We were informed that safety protocols, continuous staff training, and a culture that promoted vigilance and open communication contributed to there being no serious incidents reported. The department prioritised identifying potential risks and implemented preventive measures to mitigate them. Engaging in reflective practices and maintaining a robust incident reporting system enabled the department to monitor, evaluate, and enhance their care processes, ensuring a safe environment for both patients and staff.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff understood their responsibilities and could give examples of when they would use the duty of candour.

Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. This means providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.

Staff met to discuss the feedback and look at improvements to patient care. The incident review meeting took place every two weeks and was chaired by the head of governance. The first part of the meeting gave an overview of all incidents that had occurred from the previous couple of weeks across The Lister Hospital facilities and/or other HCA sites. Those incidents were presented and discussed, reflections and shared learning opportunities were identified, as well as how improvements could be made around processes to ensure that those incidents did not occur in the outpatients department.

There were quarterly blood management group meetings and meetings around transfusions, though this meeting was not always applicable to the department. What was applicable to the department were incidents related to blood samples, i.e. incorrect labelling of sample bottles or using wrong bottles; expired bottles; lost samples; and/or samples not being signed by two nurses. The head of outpatients told us that if the department were culpable, then the meeting was an opportunity for them to discuss and see if there was any shared learning opportunities.

Good

Outpatients

Sharps injuries were also discussed in that meeting, with those same issues also being discussed in various other meetings such as the incident review meeting and health and safety review meeting.

At 9:15am each morning there was a hospital meeting delivered via teleconference. One representative for each department attended and would provide an update on any incidents that had occurred in the previous 24 hours.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Once an incident was reported, it was assigned to the relevant head of department and to several investigators, for investigation. Once the incident had been reviewed and investigated, it was then sent to the governance team for final review and approval.

There were 118 incidents reported between November 2022 and October 2023. Twenty-four of those 118 incidents reported were clinical incidents. The highest themed incidents related to patient information (records, documents, test results, and scans).

Staff were encouraged and trained to identify and report any event that deviated from standard care or could potentially harm a patient, colleague, or visitor. This included medical errors, adverse events, near misses, and safety concerns. The hospital encouraged open and honest reporting. Staff reported incidents through a digital system. Staff were aware of the need to escalate to the senior member of staff on duty (senior staff nurse, sister, or duty clinical manager) who would decide whether to escalate to the head of department. All new staff were inducted and received training on the reporting system; this was also provided to anyone that needed a refresher. The incident reporting system also sent automatic notifications to relevant colleagues once a new report had been made.

Is the service effective?

Inspected but not rated

We did not rate this domain.

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. Policies were written based on best practice and amended as needed. Policies were reviewed in the event of a change in guidance, which could result in the change of a standard operating procedure, in line with new guidance and local risk assessment.

All policies were dated, and version controlled to ensure they remained up to date. Policies referred to national guidance to ensure the service were adhering to best practice. Policies were supported by standard operating procedures to guide staff in delivering the highest quality care.

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. Assessment of pain was completed in line with the service's pain management policy. Pain was assessed using a pain assessment verbal rating scale.

Staff prescribed, administered and recorded pain relief accurately. There was a pain tool used for patients undergoing a procedure. Patients were assessed and managed accordingly. Analgesia was given in clinic and was documented on a specific prescription chart and scanned to the patient's record.

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.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The department conducted regular audits and risk assessments to identify potential areas of improvement in the patient care processes. Audits included: chaperone documentation; hand hygiene compliance; medical devices audit; IPC principles and practices; transportation of specimens. There was 100% compliance in most audits. Where there was slightly lower compliance in audits such as IPC principles and practices, this was because there was wear and tear, which contributed to damages to the structural integrity of the building. Actions following this were to escalate those specific issues to the relevant team.

Nurses also completed follow up calls with patients and this was audited monthly. There was good compliance with this audit and feedback from the audit was shared.

Managers used information from the audits to improve care and treatment. Non-compliance with audits was set out in the organisation's corporate clinical audit policy. Where the results of a clinical audit indicated sub-optimal practice, an action plan was developed to address the shortfalls and issues raised. Not all clinical audits required an action plan for e.g. where an audit showed that there was 100% achievement of best practice and guidance had been followed. Effective action planning was dependent on the identification of the root cause of any shortfalls in practice. Action plans had to be specific, measurable and achievable, with clear implementation timescales and identified leads for each action. The audit owner for a specific audit was responsible for coordinating and overseeing the production of the audit plan and monitoring to completion.

Improvement was checked and monitored. The implementation of a local action plan was the responsibility of the audit owner responsible for a specific audit. Action plans were reviewed and updated, and reported at various meetings, including quality and audit meetings. This was done by updating the organisation's previous audit report with the latest audit data and updating the action plan contained with the organisation's audit report.

Re-audit for the department was important to determine whether agreed actions had been implemented according to the action plan and had been effective. The policy approach of the organisation was that all corporate audits would automatically be re-audited either monthly, quarterly, 6 monthly or annually. Audits could be increased in frequency (from that scheduled) to ensure shortfalls were addressed promptly, and actions were fully embedded.

Audit results were discussed at the hospital's monthly quality improvement group, where audit leads in every clinical departmental area presented results and action plans.

Good

Outpatients

The Lister Hospital had been awarded venous thromboembolism (VTE) exemplar status in recognition of the centre's excellent track record in the prevention and care of VTE, or deep vein blood clots. VTE champions within the outpatient department were instrumental in the hospital achieving VTE exemplar status.

The team had created new deep vein thrombosis patient information leaflet and created training material for staff which included, a detailed module on how to fit anti-embolism stockings correctly.

CQC ratings were listed in the main waiting area of the hospital on the Ground Floor.

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.

Managers supported staff to develop through yearly, constructive appraisals of their work. We looked at all the annual appraisals for all staff working in the department. Annual appraisals were performed for staff and held in their personal staff record. Objectives were assessed after 6 months, and good support was available if extra training was required.

Conversations were had in appraisals about what staff had in mind for their progression at different time goals such as at, two years' time, 5 years' time etc. Staff were given the tools if they wanted to progress further.

Additionally, managers would have a separate conversation with staff in a meeting called 'Learn and Grow', which was a meeting tailored to career progression. It gave staff an opportunity to reflect on where they saw themselves progressing to and how that would be achieved and the meeting was described as a coaching exercise.

The clinical educators supported the learning and development needs of staff. A receptionist who had been in post for 2 weeks told us that they had good training opportunities and were supported through their induction. They felt very much part of the team and the two senior specialist nurses had supported them "immensely".

Managers gave all new staff a full induction tailored to their role before they started work. There was a robust induction process for new starters, which included a corporate induction for 2-3 days out of the new starter's first week, followed by a local induction and then an orientation of the department. The new starter would also be given a buddy within the department.

New staff would rotate around the satellite hospitals and midway interviews took place to determine how staff were progressing. The midway interviews were also an opportunity to address any issues. Competency sheets were also completed for new starters during this time.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. The majority of staff have been in post for several years, and felt well supported and empowered to develop and progress their careers. In addition to mandatory training, staff with clear progression training(s) in mind, would have that facilitated for them where appropriate.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Whilst the head of outpatients was new in her current role, she had 1-1 meetings with the sisters already planned in her calendar.

Managers made sure staff received any specialist training for their role. The department had a tissue viability link nurses (a nurse dedicated for wound care). They attended lots of study days internally and externally and received support to do this.

The head of outpatients was completing a two-year master's degree in executive leadership, which would help them get the theoretical knowledge as well as be equipped with the tools needed for their new role.

Consultants wanting to work in the hospital under practising privileges were vetted via the medical advisory group. The CEO would ask two existing consultants from the hospital of the speciality that the applicant was applying to, to review their CV. Applicants would have to produce a bundle of pre-requisite paperwork and ensured that there were no conflicts of interest before any go ahead was given for them to work at the hospital.

There were a small percentage of consultants working in the hospital who were employed directly by the organisation.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Due to the nature of the outpatients service, there was no multidisciplinary working in the department. However, within the hospital's wider delivery of services, multidisciplinary meetings were held monthly, with good collaborative working with relevant members of teams involved in patients' care.

Seven-day services

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

The department was open from 8am to 8pm. There were no outpatient clinics on Saturday or Sundays.

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. Health promotion posters were displayed in the waiting areas, which could be downloaded by scanning a quick response (QR) code. Health promotion posters included: 'losing weight', 'drinking less', and 'getting active'.

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.

Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff were 100% compliant in Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. These assessments were led by the consultant in charge of the patients care but could be requested by any member of the team who had concerns.

Good

Outpatients

There had been zero cases where there had been a patient lacking in capacity.

Staff gained consent from patients for their care and treatment in line with legislation and guidance and made sure patients consented to treatment based on all the information available. Patients told us they would have conversations at length with consultants about their treatment options.

The department had MCA principles that staff referred to, which included: taking all practical steps to maximise a person's ability to make a decision; and to choose the least restrictive option if a person lacked capacity.

The service understood that whilst its client group were very low risk, they couldn't disregard the fact that they may receive patients who were living with a mental health issue.

The service also provided chaperones where a patient wanted to request one.

Is the service caring?

Good

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed good interactions between staff and patients, with positive attitudes observed between staff and patients at all times. Reception staff always greeted patients courteously, and staff interacted very respectfully with patients and visitors moving through the service.

Patients said staff treated them well and with kindness. Feedback that we reviewed from patients showed that patients felt that their experience with staff was exceptional and that they were treated with kindness. One patient commented on their visit to the service as, "Great. Everyone is very helpful and kind. Makes the whole experience very easy with such nice loving people taking care of you". We spoke with a patient who was visiting the service for follow-up care. They remarked on how exceptional their care and patient journey had been, complimenting staff on how good, polite and professional they were.

Reception staff were responsive and helpful to new patients visiting the service querying how to complete their registration forms. Receptionists would call through to the consultants to let them know that their patients had arrived. We observed a disabled patient being wheeled to their consultation by one of the ground floor front of house staff.

Staff followed policy to keep patient care and treatment confidential. Consultations were delivered confidentially behind closed doors. All computer monitors faced into the room and could not be observed from the doorway. Reception areas were designed as such where members of the public could not view patient information on receptionist's computer screens.

Good

Outpatients

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Cultural needs were addressed for patients and visitors by offering a prayer room and prayer mat on request. A chaperone service was always available for patients who wanted accompanying to their consultations. There were signs framed in reception areas informing patients of this provision. If a chaperone was used, it was documented on the patients record on the electronic patient record system.

A patient we spoke with told us about their positive experience on being able to access the service with such efficiency, as they had called the previous day for an appointment and were able to be seen the following day.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed a consultant who came out of his consultation and informed reception staff that their patient needed a chaperone. Reception staff quickly arranged this and then a nurse introduced themselves to the patient and asked their permission to serve as their chaperone.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. The clinical nurse specialists (CNS) team supported consultants and patients when bad news was being delivered. Members of the CNS team were sponsored to access external formal specialist training with a cancer care provider and another NHS provider. We saw evidence of a member of staff who had completed the online training with the NHS provider in 2021.

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. The hospital had a memorandum of understanding with a partner organisation who operated a private mental health and wellness centre in central London providing consultations (including coaching, counselling, psychotherapy, psychology and psychiatry) across the full spectrum of mental health disorders for adults, families, adolescents and children. There was a formalised referral pathway from The Lister Hospital and other relevant HCA facilities to this provider. Patients' main consultants were responsible for the clinical decision to refer the patients to the partner organisation.

The hospital recognised that delivering bad news was an integral yet challenging part of healthcare practice. The hospital via the hospital's partnership with the partner organisation, had also planned to introduce additional training for hospital staff who may have to deliver bad news and in particular deal with grief.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff and nurses introduced themselves to patients at all times. Patients told us that they received a lot of pre and post information prior to and after their appointments and surgery. One patient told us that they were able to ask questions without ever "feeling silly for asking those questions".

Good

Outpatients

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We spoke with a patient through a translator. They told us that they felt like they were treated with dignity and respect and there was nothing about the service they feel they wanted to change as it was an already excellent and perfect service.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patient feedback forms could be posted into a post box at each respective outpatients reception area. Feedback forms were collected on a weekly basis and placed on the staff notice board. Patient feedback forms asked two questions, which were: “How was your visit today?” and “Any feedback for improvement?”.

Patients gave positive feedback about the service. Feedback provided by patients about staff and the service was overwhelmingly positive. A patient we spoke with told us that they felt the service was a 10 out of 10 and would highly recommend the service to family and friends.

The service also collected feedback from consultants, which was collated and published on the staff notice board. Feedback from consultants included: “Outpatients service at The Lister is and has been very efficient and supportive”; “Excellent colleagues, cannot praise everyone enough! Carry on the great work!”.

Results from a patient satisfaction survey across The Lister Hospital clinic sites from November 2022 to October 2023, showed that 100% of patients felt that their privacy and dignity was maintained throughout the patients’ attendance to the service. For September and October of 2023, results showed 100% of patients asked felt that their consultant showed the patients understanding when assessing their need for treatment and that their consultant explained everything in a way that was easy for patients to understand.

Is the service responsive?

Good

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

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of 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. Planning and delivery of services was aligned to meet the evolving needs of the population that the department served, which was rooted in comprehensive market research. Market research involved analysing demographic data, health trends, and patient feedback within the community. The hospital also examined the prevalence of specific conditions and healthcare needs unique to its population. The newly introduced patient forums had the aims of inviting patients into the hospital to hear their views on how the hospital were doing, and what else the hospital could provide them with to give them not only an excellent service but also a complete one.

The department aimed to provide same day diagnostic appointments and procedures to patients needing it. In addition to this elective service, the department also offered a designated urgent appointment service. They aimed to offer appointments to patients on the same day either within The Lister Hospital facilities or within other HCA Healthcare UK facilities.

Good

Outpatients

Consultants could use The Lister Hospital facilities and its technology to deliver remote consultations, so patients could avoid unnecessary travel (especially to those that didn't live locally). Every consulting room across outpatient facilities, were equipped with camera, microphone and headset to allow remote consultations to take place seamlessly and confidentially.

Managers monitored and took action to minimise missed appointments. There was immediate follow-up when a patient missed an appointment. The nursing team would get in touch with the consultant's secretary or would make contact with the patient straight away to understand reasons for the missed appointment. There was a rescheduling policy and depending on the patient's response and the nature of their healthcare needs, the hospital offered the option to reschedule the appointment. This was coordinated efficiently to ensure the patient received timely care.

The Head of Outpatients told us that a lot of the patients who visited the service were people who lived locally, and then people who worked in the local area, who found it convenient to visit the service on their lunch break, before starting work and after finishing work. There was a small percentage of international patients who used the service, and we were told up to five international patients would visit the service each week.

The hospital's different speciality of services included: orthopaedics, dermatology, plastics, gynaecology, neurology, rheumatology, gastroenterology and colorectal. The top specialities for The Lister Hospital were gynaecology and orthopaedics.

A new outpatients centre called Nine Elms had opened up the week before we visited The Lister Hospital for our inspection. There was no outpatients activity at the new centre on the day of our inspection.

The service were no longer seeing paediatric patients, and this had been the policy since 2017.

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.

Waiting areas in all outpatient areas and in the main hospital waiting area were furnished with a range of broadsheets and tabloid newspapers, and magazines. Teas, coffees and refreshments were available for patients and visitors to help themselves to.

There was a permanent ramp for disabled access to get into the building and then there were lifts that would take patients to the designated floor they needed to visit.

There was no off-road parking and parking restrictions were in force for those considering parking on the main road directly where the hospital was. However, there was parking facilities at Battersea Park, a short walk across Chelsea Bridge. There was also a bus stop right outside of the hospital.

We were informed that blue badge holders could park in the consultant's car park at the rear of the Lister Hospital building, as it wasn't deemed fair or ideal for those patients, especially those in a wheelchair, to be transported all the way from Battersea Park.

Good

Outpatients

When patients arrived into the main hospital, they would be greeted by the front of house team and then be signposted to the relevant department they needed. If the patients required assistance for e.g. mobility issues, then a porter would take them to the relevant department. The hospital also had wheelchairs that it could use for patients with limited mobility, to transport them around the hospital.

We observed the front of house staff introducing themselves to patients and consistently offering to help carry patient's bags. We spoke with the Front of House Manager, whose transferable skills from another industry meant that they liked to assist people. They told us that it was "the little touches to customer experience that make the difference."

Registration forms were completed majority online, which established the patient's appointment date and time and guaranteed not having to complete it at the hospital. However, patients could complete the form when they arrived. Patients could contact the hospital's call-centre based in Wales to also arrange an appointment.

Waiting areas kept some procedure information leaflets. There were (quick response) QR codes for patient information leaflets. We scanned a leaflet which took us to a leaflet which provided evidence-based information about a speciality procedure.

Interpreters were accessible on request, and Language Line was the provider that was used when translation solutions were needed. We spoke with a patient who attended their appointment with an interpreter that had been arranged through the patient's embassy. Some information leaflets were in other languages.

There was a loop hearing system available for those patients and visitors who were hearing impaired.

The service did not generally see bariatric patients. There were no chairs or couches for bariatric patients but there were hoists available where needed. We were provided with an example of a recent episode of care for a bariatric patient who attended the service and provided feedback stating that they didn't feel gowns were big enough for them. This was then raised with the housekeeping department (who deal with gown deliveries). The department had since started to order bigger gowns and keep a minimum stock level of those sized gowns, if such a need were to arise again.

There were notices in the outpatients waiting areas informing visitors that their children should always remain with them and not be left unsupervised, as there was no provision for staff to supervise children during a patient's consultation.

The Lister Hospital had an onsite multi-faith and prayer room, located on the top floor, for patients who needed a private area to pray, reflect or meditate. Their satellite sites had prayer mats available and a private room could be provided as needed.

The outpatient department benefited from a dementia lead (the deputy chief nursing officer). Each outpatient site had nominated dementia champions. Dementia champions attended regular yearly training and were the local point of contact to the nursing team that needed support in the management of those patients. The department had developed some "dementia signs", which helped communication with patients suffering from dementia who were nonverbal. Additional resources were available to the nursing team to allow easier communication and management for that patient group.

All staff in the outpatient department had attended the autism and learning disability study day. Additionally, the Oliver McGowan mandatory training module was part of each member of staff's learning pathway, to make sure every member of staff was equipped with the relevant knowledge and awareness required to deal with those patients.

The front of house team informed us that they would book taxis and hail them for patients who so required.

Access and flow

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

The centralised appointment system was managed by the organisation's contact centre based in Wales. They were available to take patient queries and appointment booking queries. Clinical staff met regularly with colleagues in the contact centre to ensure they understood the department's patients' needs.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes. The department did not have any waiting lists. The hospital had an effective scheduling system that optimised the use of our resources while minimising wait times for patients. Patients did not wait more than a few days for an elective appointment. The system allowed the department to manage patient flow smoothly and address patient's individual needs promptly.

A dedicated team of clinic booking coordinators manned a dedicated phone line for patients wanting a same day appointment. Coordinators would then liaise with the consultants' secretaries to find availability.

Clinic booking coordinators populated clinic lists, which were printed at reception. Clinic lists included: the consultation room number; the name of the consultant and the patient's name. Nurses and sisters used that information to plan lists for the following day. Those patients booked in for a particular procedure, had a highlight against their name on the clinic list so that the nurses could identify and set up the room ready for those patients when and where necessary.

Booking coordinators could look at consultant attendance and utilisation. We were told by the Head of Outpatients that if there were any low attendance consultants, then discussions with them would be had and their clinic slots would be offered to other consultants where necessary if they could not fulfil those slots. We were told that reasons for consultant's sometimes not fulfilling their clinic slots were a result of changes in their NHS commitments.

The head of outpatients told us that one of the department's challenges was space, as there were some days of the week where all the consultants wanted to work in the department, so leaders would sometimes have to operate a waiting list for consultant's to be able to work in the department. This challenge had been somewhat relieved with the opening of the new 9 Elms satellite site.

Sixty-five per cent of patients who had visited the outpatient department in the last 12 months had been referred by a GP.

The outpatient waiting areas fluctuated in activity throughout the day on the day of inspection, with times when it was extremely busy and times when it was quieter.

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.

Good

Outpatients

Patients, relatives and carers knew how to complain or raise concerns. Patients could complete feedback about the service by scanning a QR code using their smart phone camera. Feedback forms and how to complain forms were also seen throughout the service areas.

The service clearly displayed information about how to raise a concern in patient areas. Complaints were managed in line with the organisation's complaints policy and patients were offered the complaints information booklet when required. The organisation were a subscribing member of the Independent Sector Complaints Adjudication Service (ISCAS) and abided by their code of practice, ensuring that patients, their families, and carers were encouraged to provide comments and feedback both positive and constructive, and felt empowered to make both informal and formal complaints.

Managers investigated complaints and identified themes. Complaints were discussed at the hospital's weekly medical governance lead meeting and weekly CEO complaints meeting, where all formal and informal complaints were tabled. Complaints were also discussed at the monthly patient experience group and other forums. Shared learning was disseminated using the organisation's shared learning template.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. There were processes in place for how patients made a complaint, whether it was an informal or formal complaint. For informal complaints, complaints would be escalated to the nurse in charge, the governance team would be informed and the nurse in charge would respond back to the complaint via the complainant's preferred method of communication.

For the period November 2022 to October 2023, the outpatient department received only three formal complaints, which related to staff behaviour, appointments and communication. All three complaints were partially upheld by the department.

The outpatient departments across The Lister Hospital and its other satellite sites, did not have any open complaints at the time of our inspection.

Staff received ongoing training in customer service, conflict resolution, and communication skills. The training ensured that staff were equipped to handle patient concerns effectively and maintain high standards of service.

Is the service well-led?

Good

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

Leadership

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

The Head of Outpatients had recently been appointed to the role, having been a Deputy Outpatients Manager previously. At the time of our inspection there was still a vacancy for the Deputy Outpatients Manager role.

Good

Outpatients

The Head of Outpatients based themselves at least once a month across satellite sites (some of which came under different CQC registrations) that fell within the Lister group but was at the Lister Hospital most days. They would complete their daily rounds across the two outpatients floors at the Lister Hospital. The Head of Outpatients would email staff at the start of her shift to let staff know where she was and how they could be contacted, as if they were not working at The Lister Hospital, then their telephone extension number would be different.

Staff working in the service told us that the senior management team were very visible and approachable, and that they were kept involved in all aspects of the hospital.

The hospital had a 'Walk in Your World' programme, where the senior leadership team would spend time in clinical areas working alongside other clinical colleagues. The team round daily, listening to and speaking with colleagues, patients and stakeholders to understand their experiences and perspective on the care they receive or deliver.

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 organisation's mission was commitment to care and improvement of human life and in recognition of that commitment, they strived to deliver high quality, cost-effective healthcare in the communities it served.

The department's strategy fed into the overall organisation's strategic framework of: delivering the highest quality of care; improving access and convenience; driving operational excellence; strengthening doctor and partner relationships; becoming the patients' provider of choice; and developing comprehensive service lines.

We observed staff in all of their interactions with patients and visitors, and they embodied the organisation's values, which supported its vision of "exceptional people and exceptional care".

A feature wall in the main waiting area of the hospital detailed how the hospital worked closely with dedicated consultants and clinical teams to provide cutting-edge medical care to every patient.

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.

The culture at The Lister Hospital, was one that was positive and was demonstrated in the examples that we were given by staff working in all disciplines. The head of outpatients told us they had an open-door policy for staff to be able to approach them about any matters concerning them.

The nursing team told us that the culture of the department was a positive one, where they were cultivated to ask for help. Staff described the working environment as a healthy one and the senior sister told us how "immensely proud" she was of her team.

Good

Outpatients

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 outpatients service held a monthly team meeting, which had an agenda and was minuted. Minutes were sent to staff after the meeting, which were also sent to the Chief Nursing Officer (CNO) as per their requests after each meeting. The CNO would attend the departmental meetings when they could.

Governance fed into the Lister Quality and Safety Board, which fed into the organisation's overall Quality and Safety Board. Within the governance function, there were a number of groups which included: the incident review group (IRG); quality improvement group (QIG); multidisciplinary groups; patient experience group; policy review group; risk management; and the learning and improvement panel (LIP).

Within the medical governance function were a number of groups that also convened meetings. These groups were the: local decision-making group (LDMG); mortality and morbidity (M&M); and the medical advisory committee (MAC). The MAC meetings were held monthly and chaired by the MAC chair

Outside of formal hospital governance meetings, the head of outpatients would have monthly catchups with the governance team, which looked at risks and incidents, reviewing all accepted risk and active risks and ensuring there were no changes to those risks.

On the day of inspection, we were informed of a meeting that took place that morning, where one senior member of each department joined the call, led by the duty manager and was attended by the CEO and CNO. The duty manager gave updates from the previous day (discussing any concerns that may have happened overnight). Each department were given an opportunity on the call to confirm whether everything was well with their respective service areas and to discuss any staffing challenges that they may face.

There was an outpatients managers group, where all the outpatients managers across all of the HCA sites would get together to discuss different topics and interesting learning. The meeting was chaired by an outpatients manager from a clinic in North London, whose idea it was to formulate the meeting group. The meeting forum was described as "nice" because the chair would invite different people to come and speak, which once included a corporate nurse who came to discuss a new policy checklist that was due to be implemented across all HCA hospital sites.

The head of outpatients would have a monthly catchup with the finance team, to go through all of the cost codes and high-cost expenditure attributable to the department.

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 department had two risks on its risk register relating to staff resilience within the department, as a result of staffing vacancies. The other risk related to the department using a portable monitor for performing flexible cystoscopies and

ear, nose and throat (ENT) procedures, and the only way to transfer the data from the monitor to the consultant was to use USBs. This was managed by password protecting the USB stick and the data from that USB stick being deleted as soon as the files had been sent to the secretaries of the consultants. This risk had a low risk rating and had last been reviewed on 3 November 2023.

The head of outpatients oversaw the regular monitoring of key performance indicators (KPIs) relevant to the department. This included patient outcomes, service efficiency, staff productivity, and satisfaction levels. Regular reviews helped identify trends and areas for improvement. The hospital had a performance improvement action plan as well as a corporate capability policy to manage issues of staff performance.

For significant events, such as medical emergencies, natural disasters, or technical failures, the hospital would activate predefined emergency protocols, such as their resuscitation policy, business continuity plan protocol and downtime procedures. These included mobilising emergency response teams, securing necessary resources, and, if needed, implementing evacuation procedures.

Ensuring continuity of care for patients during and after an unexpected event was a key focus for the hospital. They had contingency plans in place to redirect or reschedule services as required, minimising disruption to patient care.

Information Management

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

The service had an Information Governance Policy, which was owned by the data protection officer (DPO) and chief information security officer. All staff had to complete, as part of their induction, the organisation's mandatory data protection and security training, with existing staff refreshing their mandatory training on an annual basis.

The DPO monitored compliance with the Data Protection laws and provided advice to the information governance board (IGB) and all staff working across the organisation.

Inappropriate sharing of personal data and security incidents were reported on the incident reporting system. Staff gave us examples of what constituted a reportable incident, such as: the sharing of passwords; leaving personal data or confidential information unattended in public area; sending personal data to a third party in error and/or where there is no justification; and clicking on a link in a phishing email.

Staff showed us how they would encrypt messages if they were going to send an email to someone outside of their organisation.

Engagement

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

There was a patient experience meeting that took place every month and was chaired by the governance team. Feedback that was received from inpatient and outpatient areas was collated into a report and would be shared in that meeting and every department would be asked to present a presentation slide around things that had not gone well in their respective department areas.

A patient forum meeting took place quarterly and patients were invited in to share their experiences.

Staff participated in local meetings, staff meetings, daily huddles, and safety conversations around security topics. Those meetings happened daily and/or monthly and each member of staff was encouraged to give their view on how to improve services. In addition to these local opportunities, the chief nursing officer and the organisation's HR partner hosted "talkback" sessions in all facilities. This gave staff the opportunity to engage with senior members of the leadership team and share their views on how the service was doing and how it could improve.

The hospital had recently launched a 'Colleague Council' in response to the hospital's most recent 'Vital Voices' staff survey feedback, that highlighted the request for improved communication with staff. This council's aims were to make positive changes to the working environment associated with staff engagement and wellbeing, patient care and staff social activities. 'Colleague Council' representatives had the chance to attend corporate training on how to be an impactful and effective representative, learn more about the hospital operations and how to influence senior leadership. One of the nurses working in the outpatients department, sat on the council.

The 'Vital Voices' staff survey took place twice a year and had the aim to obtain staff feedback on how the departments were doing and what the departments could do better. Results were disseminated to the teams and discussed via meaningful conversations. Heads of department then created specific, measurable, achievable, realistic, and timely (SMART) objectives from the results to drive further improvement in staff engagement.

There were freedom to speak up guardians in the hospital and designated freedom to speak up champions who staff could anonymously raise their concerns to. A member of staff told us that they had previously used the freedom to speak up service.

The organisation's social media team focused on digital communication through frequent social media posts, rather than traditional paper leaflets.

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.

The organisation had recently appointed a full time sustainability officer who was working closely with The Lister Hospital to identify and champion new sustainability projects.

The hospital had developed a climate and sustainability forum that met quarterly to continuously monitor and evaluate the effectiveness of sustainability initiatives, making necessary adjustments and improvements within the hospital.

The hospital had recently started to use re-usable sharps bins, leading to a 3.5 tonne reduction in plastic waste across the Lister Hospital over the last 12 months. Changing waste streams has also led to a significant reduction in Tonnes of Carbon Dioxide Equivalent (tCO2e) waste.

In the last year the Outpatient departments across the Lister Hospital had implemented desk signs to remind consultants and staff to switch off their personal computers (rather than leaving it on standby) to reduce energy waste.

Good

Outpatients

The hospital were involved in a new electronic health records (EHR) project called “Expanse”, which was due to be rolled out in 2024. Departments were deeply involved in the data collection phase to build and shape the new EHR system according to staff requirements. With the new EHR system, all notes would be on one single system, reducing the need to have paper notes, photocopies, printed clinic letters etc.

In 2022 The Lister Outpatient Department and its satellite sites began using Ambu single-use scopes. The innovative equipment enabled the quick, safe, and efficient performance of cystoscopies and ear, nose and throat (ENT) examinations. The scopes were sustainable in that the company who were producing them, were now manufacturing them so that their products did not contain phthalates, classified as harmful to reproduction or known as endocrine disrupters.

The department had introduced a ‘1 Stop Menopause Clinic’, which offered patients the opportunity to complete all relevant investigations such as imaging and blood work in a single visit, prior to having a consultation with a menopause specialist. The service also included optional input from a dietician and clinical nurse specialist (CNS) who could advise patients on alternative or adjuvant treatment options for the management of their symptoms.

There was also a ‘1 stop clinic’ for dermatology, clinics to address various dermatological concerns within one appointment. Patients benefited from a complete consultation, diagnosis, and if necessary, immediate treatment or intervention. This approach saved time and reduced the need for multiple visits, enhancing patient convenience and satisfaction.

Outstanding ☆

Surgery

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

Is the service safe?

Good ●

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

Mandatory training

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

Staff received and kept up to date with their mandatory training. Mandatory training modules were a mixture of face to face and online training. At the time of our inspection mandatory training compliance levels for all staff including theatre, orthopaedic and general surgery, day surgery, pre-assessment and surgical wards was 98.3%, which exceeded the hospital's target of 85%.

Mandatory training was comprehensive and met the needs of patients and staff. Modules included but were not limited to, safeguarding adults and children, equality and diversity, learning disability and autism training, mental capacity act and the deprivation of liberty safeguards, infection control, immediate life support, advanced life support and basic life support.

Bank and agency staff also completed the hospital's mandatory training programme.

Staff told us they had protected time to complete their mandatory training. Clinical nurse facilitators and ward managers were responsible for monitoring mandatory training completion and received reports from the learning platform to ensure that staff were up to date.

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.

We reviewed the service's safeguarding adults policy. This was in date and available on the hospital intranet system. The policy detailed individual responsibilities, processes for reporting and escalation of concerns and who to contact.

All clinical staff were trained to level 2 and 3 safeguarding adults and level 2 and 3 safeguarding children. There was a provider level safeguarding lead who was trained to level 4 safeguarding. Compliance rates for safeguarding training exceeded the hospital's target of 85% for all modalities.

All staff we spoke with demonstrated a good understanding of safeguarding vulnerable adults and children. Staff were able to identify the potential signs of abuse, the process for raising concerns and what would prompt them to make a referral.

Staff knew how to escalate concerns to their manager and safeguarding lead. As an example, staff we spoke with had good awareness and knowledge of safeguarding issues such as domestic violence and female genital mutilation (FGM) which was part of safeguarding training.

We saw safeguarding posters around the wards and patient areas with information on how to raise safeguarding concerns.

Cleanliness, infection control and hygiene

The service managed infection risks 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.

All areas in the surgery department were clean and had suitable furnishings, which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Regular cleaning audits showed compliance with cleaning schedules.

Theatre areas were visibly clean and free of clutter. There was access to hand sanitisers throughout the hospital and we saw handwashing posters above sinks.

Staff cleaned equipment after patient contact. Cleaning checklists of clinical areas and equipment were completed daily. Additionally, we saw housekeeping staff cleaning the ward areas and completing their cleaning checklists throughout the day.

The service had infection prevention and control (IPC) link nurses who supported the ward and ensured audits were undertaken and any actions were in place. We saw examples during our visit of how all levels of staff contributed to the cleanliness of the department.

We viewed the infection control policy which was in date and accessible on the hospital intranet. The policy was comprehensive and staff could easily access it.

The service completed monthly infection control audits. Areas covered included hand hygiene, IPC principles and practice, transmission-based precautions and sharps and waste handling. Results between May 2023 and October 2023 were consistently above 90% with the majority of scores achieving 100% compliance.

Staff acted when scores were less than the 100% target. For example, they identified learning and increased awareness to improve standards of practice.

There was easy access to personal protective equipment (PPE) such as gloves and aprons. Staff followed IPC principles and were bare below the elbow. We observed theatre staff wearing appropriate PPE in theatres and practising good hand hygiene.

If a patient was infectious, a sign was put on the door of their room to indicate this to staff and visitors.

Staff worked effectively to prevent, identify, and treat surgical site infections. The hospital reported there had been no cases of methicillin-resistant staphylococcus aureus (MRSA), no cases of methicillin-susceptible staphylococcus aureus (MSSA) and no cases of clostridium difficile infections.

The hospital had a single pseudomonas bacteraemia infection relating to a critical care unit patient. This was reported to the relevant external authority as part of the service's surveillance process and investigated with the clinical department involved, the IPC team and the microbiology team. The investigation findings were reported back to the local infection control committee for learning. Learning was shared at the provider's IPC committee.

The service had 24-hour, 7 day a week access to a consultant microbiologist for advice and support during investigations and sign off of post infection reviews.

The hospital had a central decontamination unit on site. The service was registered with the British Standards Institute and had their relevant International Organization for Standardization (ISO) 13485 certificates. This ensured a quality management system that consistently met customer and applicable regulatory requirements. Processes for sterilisation of equipment were well managed, ensuring safe sterilisation and tracking of all equipment with a turnaround time of 4 hours.

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.

Surgical wards and theatres were within the main building of The Lister Hospital. Access to theatres was by keypad locked door. There were 4 theatres which were available for both elective and urgent surgery. All theatres were laminar flow. Laminar flow theatres aim to reduce the number of infective organisms in the theatre air by generating a continuous flow of bacteria free air.

The hospital had a dedicated ward for surgical patients. All patients were cared for in private single rooms with ensuite facilities. Call bells and emergency buzzers were in the main patient bedroom area as well as the ensuite bathroom.

Emergency trolleys were easily available within the department. We checked the emergency trolleys on the ward and theatre area and found that they were secured with a plastic snap lock, so it was clear if someone had accessed the resuscitation equipment. Equipment in emergency trolleys was checked daily. Record check sheets showed that checks had been signed to confirm compliance with national standards. We also checked various consumables and found they were sealed and in date.

The service's sepsis trolley was also checked daily. Consumables within the trolley were safely stored and in date.

Surgery

We checked and saw evidence that technical equipment had been serviced and calibrated regularly. We saw safety checks had been completed and logged for anaesthetic machines. Staff told us equipment faults could be reported electronically and were seen to quickly by the equipment maintenance team. Equipment we checked such as defibrillators and suction machines had up to date electrical safety tests.

Oxygen cylinders were stored securely and were in date. We inspected 3 sharps bins and found them to be correctly labelled and not filled above the maximum fill line.

The medicines rooms on the surgical ward were locked to prevent unauthorised entry. We checked consumable equipment and found items we sampled were in date and packaging was intact, indicating it was sterile and safe for use in patient care.

The hospital had access to bariatric equipment such as bariatric wheelchairs and beds. Bariatric equipment could be requested by staff at the pre-assessment stage and delivered to the ward prior to a patient arriving.

Linen cupboards and storage rooms were appropriately stocked and tidy.

Staff kept substances which met the Control of Substances Hazardous to Health (COSHH) regulations in a locked cupboard in a room accessible by staff only. We saw these were stored appropriately.

Staff told us there was enough access to computers and equipment such as PPE and consumables.

Waste management was handled in line with national standards, with different colour coding for general waste and clinical waste. All clinical bins were seen to be operated with lids and were not overfilled. Waste management and removal including those for contaminated and hazardous waste was in line with national standards.

Assessing and responding to patient risk

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

Staff we spoke with were aware of escalation protocols for deteriorating patients and the use of national early warning scores (NEWS2). This protocol is used to monitor the patient condition and included recordings of blood pressure, pulse, respirations, and temperature. We checked patients' NEWS2 charts and found them to be correctly filled in. We also saw that appropriate actions such as increasing the frequency of observations in line with increasing scores were done at the right time.

Staff on the wards used a portable handheld device where they could record patients' NEWS2 scores and observations. Observations were assessed and scored automatically which removed the chance of human error. The information was accessed and monitored in real-time by the resident medical officers and the critical care outreach team so that any indication of patient deterioration could be responded to quickly.

NEWS2 was audited quarterly. Compliance scores for the department were 100% in July 2023 and 94% in October 2023. Actions to improve compliance with the audit were taken and we saw reminders for staff available in clinical areas to improve practice.

Surgery

As part of handover before the morning and evening shifts, the nurse in charge read a safety briefing to the team. This was a briefing where nurses were made aware of patients who were high risk such as those who were unstable, susceptible to falls or had a high NEWS2 score. Staff also discussed medicines prescribed at the last shift so that no medications were missed or delayed. In addition, staff with known safety risks were highlighted so that staff allocations for the day were safe and appropriate.

In theatres, at the daily huddle, the team discussed several safety events such as unexpected outcomes, near misses or issues within the service. They also discussed theatre list themes such as volumes, delays, and topics from the latest hot board poster which highlighted incidents, changes in policy and any new risks.

The service used the World Health Organisation (WHO) five steps to safer surgery checklist effectively and we saw this was embedded into practice. Staff carried out monthly audits and the latest audits from May 2023 to October 2023 showed consistent 100% compliance for WHO documentation checklist completion and 100% compliance for the WHO observational checklist for the same period with exception in October 2023 where the service scored 99%.

Staff confirmed they had received training in sepsis and the sepsis six care bundle which consists of 3 tests and 3 treatments for the management of patients with presumed or actual sepsis. Sepsis training was recorded within each staff member's individual competency file. The service also had sepsis trolleys which contained the six elements of the sepsis six care bundle including the antibiotics needed to deliver the care bundles. The service completed monthly audits on sepsis standards and scored between 92 and 100% compliance in the last 6 months.

Patients were assessed in pre-assessment by a nurse prior to their surgery. This was conducted either over the telephone or face to face depending on the specific surgical criteria. The pre-assessment team provided advice and information to patients prior to their surgery which included ensuring any individual needs such as access to interpreters or mobility needs were arranged, as well as arranging diagnostic tests. The team told us they were able to contact the patient's consultant to ask any questions about the patient as well as engaging early with clinical nurse specialists, physiotherapists, theatre staff or surgical ward staff. This ensured that everything was in place for the patient when they arrived at the hospital for their procedure.

The service followed National Institute for Health and Care Excellence (NICE) recommendations for pre-operative tests. We saw evidence in patient notes that risk assessments had been completed. For example, patient notes recorded falls risk assessments and patients were assessed for venous thromboembolism (VTE) risk on and during admission. Patients who were at risk of falls had a yellow card placed outside of their rooms so staff could be made immediately aware of the risk. VTE risk assessments were completed for all patients and the risk was reviewed at each shift.

The service had dedicated tissue viability nurses who attended wards regularly. Nursing staff were also encouraged to attend tissue viability courses so that they could provide additional support. The pressure ulcer audit from the last 6 months showed no patients had acquired pressure ulcers while staying at the hospital on the surgical wards.

Consultants led twice daily ward rounds to review their patients' condition. Resident medical officers were on site 24 hours a day, 7 days a week and would conduct the second ward round. They would call the consultant surgeon if they had any concerns. If a patient deteriorated, nursing staff would escalate for support from the resident medical officer.

The resident medical officer would contact the patient's consultant and notify the hospital's critical care outreach team for transfer to the hospital's critical care unit. Arrangements were in place for transfer to a local NHS hospital in the case of stroke or if the patient required complex care.

Outstanding ☆

Surgery

Surgeons were responsible for attending to their patients in an emergency in line with the provider's practising privilege policy. Consultants were always required to be contactable by telephone and available to attend their patient in the event of an emergency. In addition, consultants were required to identify and ensure a 'buddy' was in place and there was named cover during any leave. Anaesthetists were responsible for the care of their patients until discharge or 24 hours post operatively, whichever was earliest. The service was also supported by on-call anaesthetists and consultants who worked to speciality specific service level agreements.

There was an on-call team which included a radiographer, theatre team and senior staff who were supported by the on-site duty manager who covered 24-hours day 7 days a week. The on-call theatre team were available for emergency returns to theatre out of hours. Members of the team had emergency life saving training including advanced life support training.

There was 24-hour access to diagnostic imaging. There was access to an on-call radiographer and access to theatres in an emergency any time of the day, which would be coordinated by the duty manager.

Staff had the right training to support patients who presented signs of deterioration. All nursing staff had completed immediate life support training, all healthcare assistants had completed basic life support training and resident medical officers had completed advanced life support training.

Bed meetings were conducted twice a day where staff shared key information about staffing pressures, patients being admitted and any issues throughout the hospital.

Nursing and support staffing

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

Staffing levels were reviewed and planned in a timely manner by ward managers using a safe staffing tool. Staff told us they received their rotas a month in advance, so they knew what shifts they were working. We saw that actual staffing levels reflected the planned numbers.

Staffing levels for the day were discussed at handovers and bed meetings and discussions included any need for cross cover across surgery and day surgery wards.

Across surgical services, there was 1 vacant post for a staff nurse in day surgery, 2 vacant staff nurse posts in the inpatient surgery ward and 2 vacant scrub practitioner posts in theatres.

Staff in theatres, wards and pre-assessment reported generally good levels of staffing and use of regular agency staffing where there were shortfalls. All agency staff received a full induction and held the same competency folders as permanent colleagues. Bank and agency staffing rates for the past year in the surgery department were 2% and 4.7% respectively.

The service mostly undertook elective surgery and was able to plan staffing accordingly. During our inspection we saw there were enough staff allocated to theatres, recovery, and the surgical wards. The service offered options to upskill staff members from other departments to support wards and theatres.

Outstanding ☆

Surgery

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.

The service had enough medical staff to keep patients safe. The service was consultant led. Consultants and anaesthetists worked under practising privileges agreements. Under practising privileges, a medical practitioner is granted permission to work within an independent hospital.

The provider ensured staff had the right skills and training to safely deliver their service. Practising privileges were granted to consultants by the medical advisory committee (MAC). Consultants with practising privileges had their appraisal, mandatory training and revalidation undertaken by the responsible officer.

The MAC reviewed and advised upon the continued eligibility of consultants' practising privileges every 2 years for those with a continuing NHS practice and annually for those consultants working exclusively in the private sector.

The hospital used resident medical officers who provided 24-hour, 7 day a week, cover on a rotational basis. Resident medical officers attended ward handovers and daily bed meetings and had constant access to the electronic observations system so they could monitor patients and attend to them quickly.

Staff reported that if they needed a patient's consultant to attend, they were able to contact them easily. In the event the consultant was unavailable, the consultant would ensure there was another consultant who covered for them.

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.

The hospital used a mixture of paper and electronic patient records to record patient needs, care plans and risk assessments.

Pre-assessments were completed by nursing staff either face to face or over the telephone depending on the type of surgery the patient was to have. Pre-assessment records included the patient's medical history, allergies, additional needs such as interpreter requirements and fasting instructions.

We were told identifiers would be placed on the records of patients who for example were living with dementia or were receiving palliative care so staff could immediately be alerted to the patient's needs.

We saw in patient records that risk assessments had been completed such as a pressure ulcer risk assessment, and a falls risk assessment.

We reviewed 8 sets of patients records and found they were comprehensive and detailed. Records noted patients' additional needs such as if a patient required additional support with regards to mobility. We saw NEWS2 observations and VTE risk assessments had been completed. Nursing audit records were done twice a year and demonstrated 100% compliance with audit targets for February 2023 and August 2023 for both surgery wards.

Care plans were in place and there was evidence these were reviewed daily. Allergies were also recorded on drugs charts. We saw evidence in patient records, and from our observations in theatres, that staff completed the safety checks undertaken during procedures using the WHO five steps to safer surgery checklist.

Operation notes were legible and postoperative plans were clearly documented. We saw there were stickers on records to be able to trace medical devices used. Implants and medical devices were recorded in the implant register book and all cosmetic implants were recorded on the Breast and Cosmetic Implant Registry.

Consultants sent letters to the patient's general practitioner (GP) with information around the outcome of consultations and procedures. Patients who were admitted to the hospital would also have a discharge summary sent from the consultant to the patient's GP.

We observed staff logging off computers after use. Information governance formed part of privacy and security mandatory training for nursing and medical staff.

Medicines

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

The hospital used systems and processes to safely prescribe, administer, record and store medicines. We saw staff on the surgical ward wearing disposable red tabards during medicines rounds so that it was clear to other staff they should not be disturbed, reducing the risk of medications errors.

The hospital used an automated medication dispensing system which ensured secure medication storage with electronic tracking of medicines. We saw that staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The medicines room was locked and only accessible to authorised staff.

Nursing staff we spoke with were aware of the policies on the administration of controlled drugs (CDs). CDs were stored in line with required legislation and recorded in a controlled drugs logbook. We viewed the logbook where staff recorded when CDs had been used and stock was checked. This demonstrated 2 members of staff checked CD stock levels. We checked a sample of these and found them to be accurate and the medicine in date.

The service had an up-to-date medicines management policy. Medicines for patients to take with them on discharge were packed and stored securely in the medicines room prior to their discharge. This also helped ensure patients could be discharged in a timely manner.

Medicines used in patients' procedures were clearly listed in the patient records. We saw in patient records that allergies were clearly documented.

Prescription pads were kept in a locked drawer accessible only by the consultant and resident medical officers.

A pharmacist visited the wards daily and checked prescription charts and CD books. Staff told us they could contact the pharmacist at any time if they had any concerns regarding medicines patients were taking. There was an on-call pharmacist for out of hours requests.

Microbiology protocols for the administration of antibiotics were available on the hospital intranet.

Room temperatures and fridge temperatures of treatment rooms were recorded daily. We checked the medicines fridge temperatures and ambient room temperature during our inspection and found them to be within expected range.

The service completed controlled drug audits and safe and secure storage of medicines audits on a quarterly basis.

Outstanding ☆

Surgery

The audit for the last controlled drug audit showed compliance above 90% for theatres and day case ward. The inpatient surgical ward had a compliance rate of 87%. The themes of non-compliance were mainly around documentation errors in the CD logbook. There was a comprehensive action plan which included additional training packages and refresher sessions for staff.

Results of the last safe and secure storage of medication audit showed compliance in all 3 areas of the department (over 90%). Action plans were identified and in place for areas of non-compliance.

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.

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and knew how to raise concerns using the hospital's electronic incident reporting system in line with the hospital's incident reporting policy. Managers investigated incidents and shared lessons learned and feedback with the team at team meetings. There was evidence that changes had been made as a result of feedback. We viewed the minutes of team meetings which showed discussion of incidents and the learning from them.

Between November 2022 and October 2023, staff reported 118 incidents, of which 97.4% were no or low harm. There were only 3 incidents reported as near misses. There were no incidents reported as moderate harm, expected deaths or unexpected deaths.

The service had 'hot boards', which were posters disseminated to staff with information on learning and actions from incidents, policy changes and new additions to the risk register. Hot board posters ensured staff who were not on shift during ward meetings or briefings could still be informed of important changes, learning and actions.

The provider ceased undertaking root cause analysis in 2022 as part of their planned phased transition to the Patient Safety Incident Response Framework (PSIRF); utilising an investigation report template instead. They launched the plan in October 2023 and no patient safety incident investigations had yet occurred.

Staff we spoke with were able to explain the duty of candour fully and in a knowledgeable manner. We saw investigations from incidents where the service had applied the duty of candour from 2021 and were assured the principals had been applied correctly. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Is the service effective?

Good

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

Evidence-based care and treatment

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

The service delivered care in line with national clinical guidance. Staff had access to policies and procedures based on national guidance on the hospital intranet.

We reviewed a sample of hospital policies including safeguarding adults, medicines management, infection control, and the theatre operating policy. These were all in date and appropriately referenced national guidance and best practice such as that recommended by the National Institute for Health and Care Excellence (NICE), Royal College of Physicians and the Association of Surgeons of Great Britain and Ireland. We also saw that patient pathways and protocols were based on national guidance.

Local safety standards for invasive procedures (LocSSIPs) were embedded in practice. The service had a single theatres LocSSIPs policy to ensure all surgical procedures that take place within theatres followed the same LocSSIPs and the relevant World Health Organisation (WHO) checklist dependent on the type of procedure taking place. Theatres LocSSIPs awareness was part of the induction programme and reading of the policy was a mandatory requirement for all staff members.

The service used evidence based 'care bundles'. A care bundle is a set of evidenced based interventions that, when used together, can improve patient outcomes. Changes and updates to policies were disseminated to staff at team meetings and by email.

We saw there was a formal annual clinical audit programme to evidence performance monitoring, quality measures or patient outcomes relating to surgical services. The audit programme detailed the frequency at which the audits should be undertaken and included but not limited to, audits for WHO five steps to safer surgery, medical devices, infection control, pain, hand hygiene, sedation, consent documentation, do not attempt resuscitation (DNACPR); sharps and waste handling, and early warning scores.

The service used an audit reporting tool and dashboard which summarised audit results so staff could identify any gaps and take appropriate actions. Actions and learning from audits were discussed at monthly meetings with the head of department and departmental audit champions. Learning and actions were then further escalated to the corporate clinical audit and effectiveness committee. Audit results were shared at the provider's monthly quality governance committee and board meetings. We saw from theatre and ward team meeting minutes that audit results and any actions were also discussed in detail.

Patient outcomes

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

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Actions and learning because of the audit programme were discussed by heads of department and departmental audit champions and disseminated to individual surgical team meetings.

Audits were completed on an electronic auditing system. This allowed for results and trends to be generated and shared effectively. Staff received training in the use of the electronic auditing system during their induction. On the wards staff were allocated to undertake various audits so that the team were fully involved in the auditing process and could take ownership of the specific audits, actions and learning.

Surgery

To monitor the quality of care and outcomes, the provider monitored key performance indicators such as activity reviews of surgeons. Reviews of a consultants' activity were undertaken annually if they had private practice only or every two years if they practised within the NHS as well as private.

Adherence to and understanding of NICE guidelines was embedded and evidenced through the use of audit programmes to benchmark practice. The hospital collected data and benchmarked against international and national audit standards.

All returns to theatre were discussed at the hospital's monthly quality governance committee where themes, trends, learning, and actions were identified. Findings were presented at the hospital's monthly board meeting, the quarterly medical advisory committee meeting and quarterly clinical operating report meeting. There were 4 returns to theatre in the last 6 months, which meant only 0.1% of procedures between May and October 2023 resulted in a return to theatre.

Orthopaedic patients for hip, knee and shoulder joint replacements were consented for their details to be submitted to the National Joint Registry (NJR) to align with national standards. Results from these were aligned to the national average and within the expected range.

The hospital also collected data for patients undergoing breast and cosmetic surgery to the Breast and Cosmetic Implant Registry.

The service participated in patient reported outcome measures (PROMS). Patient reported outcome measures assess the quality of care from the patient perspective. Each patient is invited to give feedback on the outcomes of their surgery by responding to questionnaires before and after their procedures. Improvements in health could then be assessed by comparing the answers. Results were generally positive with patients reporting an improvement in health status following procedures on shoulders, hips and knees.

Departmental performance was also presented to monthly hospital board meetings. This ensured patient outcomes and key performance indicators were monitored at escalated to all levels of the hospital.

Patients were given surveys to complete including post discharge and these was collated and submitted to the private healthcare information network (PHIN). PHIN is an independent patient information network which works to empower patients to make informed choices about their care provider. PHIN data was presented and discussed at monthly board meetings.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service adjusted for patients' religious, cultural, and other needs.

There were appropriate arrangements to ensure patients' nutrition and hydration needs were met on the wards. The service used evidence-based tools to screen for malnutrition. We saw in patient records a malnutrition universal screening tool (MUST) tool was used for assessing patients' nutrition. We also saw fully completed fluid charts which were used to monitor patients particularly after a surgical procedure.

The service had dedicated dietitians to support nutritional planning for patients. The hospital had its own catering team who prepared fresh food for patients. Food menus catered for different patient groups including those with specific dietary requirements such as allergies, intolerances, and religious needs.

Admission times were staggered so fasting times could be minimised. Fasting instructions were given to patients at the pre-assessment stage and patients told us the staff checked with them that they understood the instructions.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain audits were undertaken on a quarterly basis and results from the last quarter for the whole hospital was 99%.

We saw in records that patients had been prescribed and administered pain relief and this had been recorded accurately. Records we reviewed also showed that patients' level of pain was assessed as part of their observation records.

Patients' pain levels were reviewed by the anaesthetist in the recovery area to ensure they were comfortable before returning to the ward. A pain management team assisted the surgical wards to support patients in pain.

Patients we spoke with told us their pain had been managed appropriately and they generally received pain relief in a timely manner.

Patients were given a telephone number of the ward and their clinical nurse specialist and were encouraged to call if they had any concerns about pain.

Competent staff

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

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

New staff received a comprehensive corporate induction as well as a department specific local induction. In theatres, the induction was separated out into key areas (surgical, anaesthetics and recovery). All new starters were allocated a 'buddy' and were supernumerary for their first 2 weeks. Staff were given the provider's orientation booklet containing sets of objectives which were required to be achieved and completed during their probationary period.

In theatres, new starters were paired up with a buddy for their first 30 days and were supernumerary while they were introduced to the team and department.

The service used regular agency staff to ensure continuity of care. There were specific induction packs for agency staff.

Staff told us their training needs were met, and managers were always willing to support their development. The provider had access to an education centre which was a dedicated space for staff to use for reflection, and different types of learning such as simulation, classroom teaching, one to one teaching/coaching, computer access for virtual learning or professional study.

All staff working within robotic surgery attended study days and were trained in theoretical knowledge and practical skills for robotics with competencies requiring sign off.

Staff told us they had been supported to access leadership and management courses, attend conferences, or gain further qualifications in specialities that they were interested in. At the time of inspection, 100% of staff in surgical services had completed their appraisals. There was also a clinical practice facilitator for surgical wards and theatres who supported the development of staff.

Revalidation was introduced by the Nursing and Midwifery Council (NMC) in 2016 and is the process nurses must follow every three years to maintain their registration. Nursing staff told us they were supported with their revalidation through clinical supervision.

The service provided competent care and training to staff. The service had clinical nurse specialists whose role was to create protocols, resources and provide training to staff. Their role was seen as a form to aid the patients' hospital journey and improve patient experience. The service also had assigned link nurses for specialist advice and support for staff.

All consultants under practising privileges received an induction pack which included details on what was required of them to practise at the hospital. Each application for practising privileges was assessed by the medical advisory committee (MAC) and we saw evidence of this in the MAC minutes we reviewed.

If a surgeon wished to bring surgical first assistants to theatre, they were required to submit a recommendation to the provider and the first assistant would then have to have their competencies signed off by the provider before they began working at the hospital.

Multidisciplinary working

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

We saw evidence of good multidisciplinary team (MDT) working.

Nursing staff said consultants and resident medical officers were always available for advice and support and there were good working relationships between colleagues. We observed in theatres that each member of the team was treated with respect. Minutes from governance meetings showed a good multidisciplinary discussion around audits and celebrated good practice by team members as well as improvements required.

We observed multidisciplinary approaches to care planning for patients and families. Patient records demonstrated input from the full clinical team of doctors, nurses and allied health professionals such as physiotherapists and dietitians, from the pre-operative assessment through to post-operative care.

Letters were sent to the patient's general practitioner (GP) to share outcomes and discharge information. The discharge letter included contact details should another health professional require further advice about the patients' care or post discharge treatment information.

Handovers and daily huddles included the full multidisciplinary team. Team meetings were multidisciplinary and included nursing staff, resident medical officers, clinical nurse specialists and physiotherapists. We saw physiotherapists liaising with nursing staff and saw that patient records had input from all MDT members.

Surgery

There were formal MDT meetings held for surgical patients. Staff we spoke with who attended the MDT meetings spoke of how there was a holistic discussion about the patient's needs and how communication was clear and inclusive. We attended an MDT meeting and observed good attendance by the full multidisciplinary team including radiologists, nurses, and surgeons where discussions and challenges were detailed, holistic and considered the patient's needs.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. In addition, there was a resident medical officer on every shift who was available 24-hours a day, seven days a week.

Staff could call for support from doctors and other disciplines such pharmacy, and diagnostic tests, 24 hours a day, 7 days a week.

Patients who had been discharged were given the number of the surgical ward to call if they had any questions or queries and a nurse or doctor would be able to provide advice if required. Patients were also given the number of their clinical nurse specialist regarding specific questions about their condition.

Health promotion

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

Patients' health was assessed at the pre-assessment stage and staff provided additional information to support patients to live a healthier lifestyle. For example, patients were provided with booklets regarding their surgery and what to expect during the preparation, surgery and recovery stage.

The service had relevant information promoting healthy lifestyles and support on wards including leaflets on healthy eating, smoking cessation, and getting active.

Clinical nurse specialists and other health professionals provided key information on how patients who were on the surgery pathway, could manage their health and improve their clinical outcomes.

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.

We saw completed consent forms in all 10 patient records we reviewed. We observed consent being confirmed with patients in theatre prior to anaesthetisation. Written consent including anaesthetic and surgical consent was sought from the patient. Written consent was also sought prior to surgery and on the day of surgery. Patients undergoing reconstructive cosmetic surgery were given a cooling off period of 14 days where they could change their mind about their decision. This was in line with national standards.

The consent audit documentation from the last quarter (July 2023 to September 2023) showed scores achieved ranged from 95% to 100% for the surgical areas.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They also 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.

Outstanding ☆

Surgery

Staff received training on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). Staff were able to give clear explanations of their roles and responsibilities under the Mental Capacity Act 2005 (MCA) regarding mental capacity assessments and Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Outstanding ☆

Our rating of caring improved. We rated it as outstanding.

Compassionate care

Staff treated patients with exceptional compassion and kindness, respected their privacy and dignity, and took account of their individual needs. People thought that staff went the extra mile and said care and support exceeded their expectations.

Staff were discreet and responsive when caring for patients. We observed staff on the surgical wards and theatres building rapport with patients and taking the time to interact with them and their loved ones. During our inspection we saw a patient leaving the ward after their stay and thanking staff for their support and the life changing impact they had on them.

Staff were focused on delivering patient centred care and respected the individual needs of each patient, showing understanding and a non-judgmental attitude when caring for patients. We saw in theatres that staff made every effort to always maintain the patient's dignity. This included showing compassion and empathy for people who had been impacted significantly both physically and mentally by their conditions.

Staff we spoke with understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for patients. Staff in pre-assessment were committed to ensuring patients felt at ease from the beginning of their journey. They told us they ensured input from all members of the team such as dietitians and interpreters and surgical ward staff were involved at an early stage, so patients felt at ease and their needs were met. Patients knew who their team was and told us they felt ownership of the process.

Staff we spoke with understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. Patients we spoke with told us staff were "Always respectful and kind," "Accommodating, friendly and helpful". We spoke with patients who told us that staff were "incredible" and were "Always available whenever I needed anything".

Patient feedback from the last 12 months was consistently positive and 100% of patients agreed they were treated with respect and dignity while in the hospital. We heard examples were staff went above and beyond with complex situations to ensure people felt cared for, welcomed and not standing out due to their medical history.

Emotional support

Staff empowered and provided strong emotional support to patients, families, and carers to minimise their distress. They understood patients' personal, cultural, and religious needs and made sure this was reflected in how care was delivered.

Surgery

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. Staff described to us how they had supported patients who had additional needs and made time to support family members and carers to allay any anxieties they had.

Patients told us staff supported them emotionally when they were feeling tearful and spent time with them to understand their needs and concerns. They told us staff were respectful of their cultural needs including choice of food.

Staff empowered patients to feel confident with any new adaptations or adjustments required following surgery. Patients commented on the continuous physical and emotional support staff gave to them following surgery and how they were more positive when approaching their new lives.

We viewed thank you cards which praised staff for their care and support. Cards we viewed included comments such as "Thank you for being a shoulder to cry on," and "[Thank you] for helping me and my family through a difficult time."

Patients were given a telephone number for the ward as well as the direct telephone number of their clinical nurse specialist for advice and support. Clinical nurse specialists told us they called patients once they were discharged to check on their progress and answer any questions or concerns, they had. They also reiterated to patients that they could call them directly for advice or support.

In the patient feedback questionnaire, there was an overwhelming sense that staff were always available to talk about the patients' worries and fears. In the 12 months prior to our inspection, patients scored the availability of staff to talk about their concerns consistently above 98%.

Understanding and involvement of patients and those close to them

Staff were fully committed to supporting patients, families, and carers to understand their condition and empower decisions about their care and treatment. Consideration of people's needs was consistently embedded in everything staff did. Patients told us they valued their relationships with staff.

Staff involved patients in decisions about their care and treatment. Patients told us they felt comfortable asking their consultant any questions they had and felt involved in their treatment plan. We saw examples of this in inpatient rooms where each person had a personal board at the entry of the room, which outlined the goals of the day for the patient, as well as any learning opportunities about their condition and updates on their discharge plan.

Patients told us they felt informed throughout their treatment and that staff also kept their family and carers informed. They told us the risks and benefits of surgery were explained to them in detail and they were given time to think it through and ask questions. Family and carers also highlighted they knew what to expect and were shown how to best support patients when they were discharged. Everyone said consultants were happy to repeat explanations so that they could understand better.

We observed staff accompanying a patient who was being discharge to the exit and checking they had all the information they needed and understood when their follow-up appointments were. This was embedded practice and part of the care ethos of the service's team.

Staff told us that finances would be discussed in detail prior to a patient's admission into hospital. If they had any questions while in hospital, there was dedicated team who could be called and support patients regarding financial matters.

Outstanding ☆

Surgery

The hospital gathered patient feedback on several aspects of care throughout the patient journey. In the last 12 months, results were consistently between 98% and 100% for the questions: 'Did your consultant show you understanding when assessing your need for treatment?' and 'Did your consultant explain everything to you in a way that was easy to understand?'

Is the service responsive?

Outstanding ☆

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

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of the patient population. People's individual needs and preferences were central to the delivery of the service. The service was delivered in a way to ensure flexibility, choice and continuity of care.

The Lister Hospital provided day surgery and inpatient care for adults requiring a variety of surgical procedures. The consultant led service included orthopaedic, gynaecological, and general surgery. The hospital provided surgical treatment for private patients from the UK as well as from overseas.

The service was proactive in analysing what people's needs were and how they could best meet them. Governance processes, live data analysis and patient feedback led the service in identifying which surgeries had the highest throughput and looking to identify what the population needs were going to be in the future.

The facilities at the hospital met the needs to deliver the service effectively. The hospital had 4 theatres, which in addition to traditional surgery also used robotic surgery. The service also had an inpatient surgical ward with 21 beds and a day surgery ward with 20 beds, of which 10 were being refurbished. Rooms had ensuite and were single occupancy. Support services, such as the pre-assessment team, physiotherapy and sterilisation services were located on-site facilitating the patient care pathway and access to the right resources in a timely way.

The service was open 7 days a week and admissions to the surgical inpatient wards and theatre lists were planned in advance. Emergency readmissions were accepted, and surgeons were notified of emergency admissions by the hospital's admissions office. Urgent unplanned admissions were also accepted once they had been triaged by the provider's centralised acute admissions service which provided a 24-hour 7 day nurse-led, medical concierge and triage service with the support from a consultant physician for referrals which met the provider's admission criteria. The team could allocate patients to one of the provider's hospitals depending on where they lived and what kind of treatment they required.

Managers planned and organised the service so they met the needs of the patient population. As the hospital provided private elective surgery, appointments could be planned to suit patients' schedules.

The surgical service provided an enhanced recovery after surgery (ERAS) programme. ERAS is an evidence-based approach to surgical care aimed at minimizing the stress of surgery and supporting patients to recover quickly through maintenance of normal physiology.

The service had developed processes prior to surgery, where patients were encouraged to play an active role in their care. The service actively provided this to support people's needs before and after the surgery.

Surgery

Following surgery, patients were encouraged to stay active, drink plenty of clear fluid and eat as soon as they are able and keep an ERAS programme diary in order to monitor their progress. Patients were also offered physiotherapy to speed up recover and aid a faster discharge from hospital. The hospital also had an on-site rehabilitation gym.

The hospital was located in central London, with good public transportation links, making it accessible to patients from a wide geographical area.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff went above and beyond to make reasonable adjustments to help patients access their services. There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met these needs, which was accessible and promoted equality.

The service was inclusive and took account of patients' individual needs and preferences. Patient records detailed a patient's additional needs such as mobility, hearing aid use or interpreter requirements. Staff made reasonable adjustments to help patients access services.

Patients we spoke with told us they were able to book surgery dates to suit their plans and commitments. We also heard of examples where staff went above and beyond to accommodate for people's allergies and phobias.

Upon discharge, patients were given a discharge information leaflet and pack which contained a telephone number to call at any time if they had any concerns. They were also given the telephone number of the clinical nurse specialist for their condition whom they could contact with any questions they had.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff told us although they rarely treated patients living with dementia and learning disabilities, this would be flagged at the pre-assessment stage and patient passports and communication aids would be used to support the patients. Staff told us they had recently supported a patient with autism and worked with the patient and their carers to ensure the patients' needs were met throughout the journey from pre-assessment through to discharge such as ensuring familiar staff members and allowing the patient to visit wards and theatres beforehand.

The hospital had internet (Wi-Fi) for public use. Patients we spoke with said they were able to access the Wi-Fi easily.

The hospital had on-site Arabic interpreters and used an external contractor to provide interpretation services for other languages as well as British sign language. Interpreter services would be arranged from the point of booking at pre-assessment.

Patients were given a choice of food and drink to meet their cultural and religious preferences. We saw food menus and saw that there was a wide range of choices for patients who required halal, kosher or vegetarian meals. The menu also catered for patients with food intolerances or allergies. Patients could also request food that was not on the menu and a form was available which was sent to the catering team with the specific requests.

There was a spacious multi-faith room. The hospital chaplaincy service was multi-faith and provided spiritual support 24-hours a day, seven days a week. Staff were aware of how to contact chaplaincy services for patients and their families.

Leaflets we saw on the wards were in English, but staff told us patients could request the leaflets in another language and this could be provided to them. There were some posters on walls in patient rooms and nurse's stations that had been translated into other languages.

The service had an up-to-date discrimination prevention policy that was compliant with the Equality Act (2010), to ensure staff delivered care without prejudice to people with protected characteristics. All staff undertook equality and diversity training and there was a clear care and treatment ethos based on individualised care.

Access and flow

People could access the service when they needed it and received the right care promptly. There were no waiting times or delays in accessing services and people could access appointments in a way and at a time that suited them.

There was timely access for surgical services at The Lister Hospital. Admission could also be facilitated at short notice to meet patients' individual needs. There were no waiting times for referral to treatment or delays in accessing services. Any waiting times to access services were driven by patient choice and patients could be seen within days and sometimes on the same day. Patients we spoke with told us they did not have to wait long for their procedure to be arranged.

Admissions for surgical procedures were elective and planned in advance. Patients were admitted by consultants with practising privileges following an outpatient consultation.

Patients requiring urgent unplanned admissions were managed by the duty manager who was available 24 hours a day, 7 days a week and supported by the provider's centralised acute admissions service.

The service used the first case on time initiative ensuring that the first operative case was started on time to prevent any delays with later cases on the list. Patients had a designated room on one of the surgical wards which was reserved from admission so there were no delays moving patients back to the ward.

There were enough beds on the wards for patients who required an unexpected stay overnight. The number of expected admissions was discussed at daily bed meetings. The average length of stay across all specialities for elective surgery was 0.53 days.

An on-call theatre team was available in the event of an emergency and consultants were required to be contactable at all times while their patient was in the hospital.

Staff told us the discharge process was effective and they had few cases of delayed discharges. Medicines to take away were prepared before discharge so a patient did not need to wait for this upon discharge. There was a multidisciplinary team meeting for complex discharges where family members were involved in the planning of a patient's discharge.

Of the 3253 cases performed at the hospital from May 2023 to October 2023, 233 (7.8%) were cancelled. Of the cancelled cases 86 (37%) were rescheduled. In the period reported the highest 3 reasons for cancellation by the patient were for personal reasons (17%), cancelled not rebooking (15%) and 15% with no reason given. All cancellations were reported via the service's incident reporting system and lessons were learnt to improve cancellations rates where appropriate.

The service minimised cancellations with the support of schedulers who worked closely with patients to follow up any cancellations, and with the surgeon's secretary to rebook at a convenient time for the patient.

Outstanding ☆

Surgery

Patients received a discharge information pack when they were discharged from the hospital. This included a telephone number to call the ward at any time of the day as well as a number for the clinical nurse specialist. The clinical nurse specialist called patients post-discharge to check that the patient was recovering well and if there were any questions they had.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. The service was able to demonstrate where improvements had been made as a result of learning from complaints.

The service had an up-to-date complaints policy which provided guidance on how to manage complaints. Complaints were overseen and investigated by the ward manager and any learnings from complaints were discussed with teams during team meetings and huddles as well as being displayed on departmental quality boards to help improve daily practice.

Patients we spoke with were aware of how to make a complaint and told us they felt comfortable about speaking directly with staff if they wanted to complain.

Patient complaints were managed in line with the provider's complaints policy and patients were offered the complaints booklet when required. The service was a subscribed member of Independent Sector Complaints Adjudication Service (ISCAS) and abided by their code of practice which ensured that patients, their families, and carers were encouraged to provide comments and feedback both positive and constructive and feel empowered to make both informal and formal complaints.

For the period between November 2022 and October 2023, the surgery department received 3 formal complaints. Of the 3 complaints raised 2 were fully investigated within 20 days and 1 within 12 days of the complaints being made.

The main themes from the complaints were around clinical treatment pathways (2) and accommodation (1). We saw that complaints processes were well managed with learning outcomes identified for all complaints. Learning and final outcomes were also shared at the quality clinical operations report meeting, the monthly board meeting, and the quality governance committee meeting. Learning was also shared among heads of governance at other provider facilities to promote learning and good practice across all of the providers services.

Patients and families could give feedback by filling in feedback forms which were given to patients on discharge. The service clearly displayed information about how to raise a concern in patient areas and on their website.

Is the service well-led?

Outstanding ☆

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

Outstanding ☆

Surgery

Leadership

Leaders had the experience, capacity, and abilities to run the service. They understood and managed the priorities and issues the service faced. There was an embedded system of leadership development and succession planning. They were visible and approachable in the service for patients and staff.

There was a clear management structure with defined lines of responsibility and accountability. This was evident for the whole surgery department as well as within each clinical area of the service.

Day to day leadership of the surgical service was managed by the ward and theatre managers and overseen by the chief nursing officer and surgical services manager.

Departments collaborated well and shared a common focus of delivering high quality patient centred care.

Leaders at all levels demonstrated high levels of experience and capability to deliver sustainable care. They had a comprehensive understanding of challenges and had a good grasp of the priorities of the surgical service such as the continued development of robotic surgeries, staff development and improvement of the onsite facilities.

All staff spoke highly of their managers. They commented on the friendliness and visibility of the senior leaders. Staff we spoke with knew the names of the senior leadership team and told us that senior leaders regularly visited the wards. This was part of the “Walk in your world” initiative which encouraged senior leadership members to spend time in clinical areas alongside patients and colleagues to understand their experiences and perspective of care. Staff told us there was good teamwork and support within surgical services.

Leadership development was embedded within the service. Staff told us they were supported by their managers to develop their skills, access development opportunities, and take on more senior roles. Staff across wards and theatres consistently told us how they were supported to access courses and gain additional qualifications.

There was inclusive and effective leadership at all levels. Senior staff told us how they empowered staff to develop professionally and contribute to the development of the service. The hospital ensured there was an established succession strategy where there was a focus on developing staff so there was always someone ready to step into key roles within the hospital.

There were various study days which staff could attend, and ward managers also conducted away days for staff to provide extra training and development opportunities. In addition, ward managers encouraged staff to observe cases in theatre to help with their learning and development. Staff told us that consultants were very welcoming and encouraging of this.

The service supported staff development by using the '9 box grid'. This was an employee assessment tool that charted employees across nine key data points in order to develop tailored professional development plans to strengthen their role and prepare them for further career advancement. The service also followed a 'one ready now' strategy where there was a focus on developing staff so there was always someone ready to step into key roles within the hospital.

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 vision and strategy had supporting plans and objectives which were innovative and achievable.

Surgery

Staff we spoke with knew about the hospital's mission statement: "committed to the care and improvement of human life."

The Lister Hospital's strategic growth plan was reviewed annually and aligned with the 'One HCA' overall vision. The strategy and supporting objectives were challenging and innovative while remaining achievable. The 5-year strategic plan focused on the following: growing as one HCA UK, exceptional people exceptional employer, partnering with outstanding consultant teams, proving our value, sustainable business, routes to new patients, seamless patient support, and geographical growth. Each member of the senior management team was allocated to and responsible for the development of each strand of activity. There was a clear focus on creating succession plans for all heads of departments and leaders and celebrating staff who have provided excellent patient care and customer experience.

We saw the hospital's values and objectives were displayed in the service and staff told us that service objectives formed part of discussion in team meetings and away days. Staff we spoke with knew and understood the values and objectives for their service, and their role in achieving them. They spoke to us of their commitment to providing safe care and improving patient experience.

The surgical service had a clear vision and set of departmental objectives, which were focused on delivering safe, high quality, patient centred care. There was a focus on professional development, upskilling of staff on wards and celebrating exceptional care and work through feedback and awards systems.

The surgical service had several strategic growth drivers for each speciality within surgery. As an example, the hospital had a focus on maintaining itself as a centre of excellence for endometriosis care. To support the growth of this speciality they offered complex surgery treatments, collaboration with other speciality surgeons, patient focused multidisciplinary teams and dedicated nursing. There were also plans to further establish robotic gynaecological procedures through consultant recruitment and engagement including training at the hospital. The service planned to continue recruiting and embedding robotic surgeons from the local community and further.

The service also aimed to continue to help reduce pressure on local NHS hospitals in the provision of surgical services across a range of specialities.

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 opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff spoke of good teamwork in a patient-centred environment. They were passionate about their work, and we saw this in our observations of positive and supportive relationships between senior leaders, consultants and staff at all levels within the surgical service. We also saw positive, nurturing conversations with patients and all levels of staff.

We found an open and honest culture and staff told us they felt supported by their managers to develop. They gave examples of how they were encouraged to develop, such as attending conferences, and completing extra courses. Staff told us that they were empowered by their managers to raise their profiles and develop in their careers.

Staff throughout surgical services were welcoming and friendly and focused on providing high quality care for their patients. Leaders promoted a positive culture which supported and valued staff both formally and informally. As an example, the provider held bi-monthly talkback sessions to give staff an opportunity to share their feedback and thoughts on their working environment.

Surgery

Staff consistently told us they were proud to work at the hospital. They consistently spoke of good teamwork and collaboration between teams at the hospital.

The provider promoted the safety and wellbeing of staff. There were various forums and employee resources such as the employee assistance programme, expert wellbeing webinars and mental health first aiders to support staff wellbeing. Other examples of looking after staff well being included resident medical officers having their own dedicated room to use to rest when on duty overnight or between shifts.

Staff told us the management team listened to any concerns or issues they raised. There were consistently high levels of constructive engagement with staff in surgical services. This was evidence throughout the governance meeting minutes we reviewed and acknowledged at different levels of the service.

Staff at all levels were actively encouraged to raise concerns and told us they felt able to report concerns to their managers. Staff, patients, and families were encouraged to provide feedback and raise concerns without fear of reprisal. Staff were aware of the Freedom to Speak Up champions within the hospital and other champions across HCA UK facilities whom they could also approach as an alternative route to raise concerns. Staff confirmed there was a culture of openness and honesty and they felt they could raise concerns without fear of blame.

The service promoted equality and diversity in daily work. Information was readily available for staff to improve their knowledge and understanding of the needs of people with protected characteristics. The diversity and inclusion group carried out activities which raised awareness and support across numerous topics, including black history month, world kindness day, international day of zero tolerance for female genital mutilation and united nations international day of education.

Governance

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

Staff we spoke with had a good awareness of governance processes and knew how and where to escalate their concerns.

The provider ensured all staff had a good understanding of governance. The governance team provided virtual workshops and drop-in sessions to support governance refreshers and support staff on how to use their systems and processes effectively.

The service established clear lines accountability for governance processes and had an effective escalation process from board to floor and vice versa. As an example, the provider quality and safety board analysed information escalated by the Lister Hospital quality and safety board. To support this review process there where 6 governance streams, responsible for reviewing, escalating and processing relevant information. These streams included governance, medical governance, nursing, surgical services and allied health professionals (AHP), health and safety and facilities, invitro fertilisation, and medicines management. Within each stream specialist governance meetings and groups were set to support information processing and assure that all levels of management and staff were aware of how the service was performing and what could be done to improve patient and service outcomes.

Outstanding ☆

Surgery

Ward and theatre teams held monthly team meetings to discuss incidents, audit results, and safety alerts. We reviewed a sample of meeting minutes from teams within the surgical service and found they showed a comprehensive discussion of departmental audit results, patient feedback, risks, incidents, and learning. Part of the agenda of some of these meetings included welcoming new staff as well as recognising employees of the month. Ward managers told us that debriefs occurred on the ward following an incident, in addition to the monthly team meetings.

There was a theatre user group which comprised a multidisciplinary team of staff including consultants, the medical director, the chief operating officer, the surgical services manager, theatre managers, theatre practitioners, and anaesthetists. Discussions were around theatre utilisation, World Health Organisation (WHO) checklist audit results and actions, staffing, pharmacy updates and governance updates. Staff told us these meetings were very useful and was a responsive system of allowing staff to voice concerns or suggestions and be heard by senior leaders in the meeting who could take ideas forward at pace.

The medical advisory committee (MAC) met quarterly and reviewed clinical quality and governance matters including risks, incidents, new services, patient experience, recruitment, and practising privileges. Medical practitioners had their appraisals monitored by their responsible officer as part of the requirements of their practising privileges agreement. The chair of the MAC assessed applications for practising privileges and these applications would be discussed at the MAC meeting.

The hospital had committees such as patient experience, resuscitation, quality governance, infection prevention and control (IPC), learning and improvement where representatives from the surgical service would attend and feed back to their teams at the monthly team meetings.

The hospital held monthly mortality review group meetings which provided oversight of all in-hospital mortality and assurance that mortality reviews were being undertaken. Attendance at the meetings were multidisciplinary and included the medical director, the chief nursing officer, clinical nurse specialists, ward managers, and the lead resident medical officer. Minutes showed comprehensive and detailed discussions of each case which was then shared with the relevant MDT.

In 2022 a new audit reporting tool and interactive audit dashboard was launched. Each month, every department received their audit results and a summary of any non-compliant questions. This gave clear transparency of results and allowed staff to identify any gaps and report meaningful actions for particular questions. Staff were able to document what they were proud of, any gaps identified and actions for the following month.

On completion of audits, the results and findings were presented at the facility audit, governance or quality meetings, for discussion, with agreement of action plans and a commitment to complete another audit cycle within a designated timeframe. Audit results were escalated appropriately to the corporate audit group, corporate audit committee and clinical governance committee if required.

The hospital produced a quarterly clinical operating report. The report reviewed and monitored key performance indicators on quarterly basis such as mortality and unplanned returns to theatre, as well as infection control, surgical site infections, incidents, and patient experience. We saw from minutes that the report was reviewed and discussed at the monthly hospital board meetings.

Outstanding ☆

Surgery

Management of risk, issues and performance

Leaders and teams demonstrated commitment to best practice performance and risk management systems and processes. They identified and escalated relevant risks and issues and identified actions to reduce their impact effectively and in a timely manner. They had plans to cope with unexpected events.

The hospital identified risks through different sources such as audits, incidents, patient and staff feedback, inquests, risk assessments and safety alerts. Risks were raised by the head of department and risk manager and presented at the weekly complaints, litigation, incidents, and patient experience meetings. We saw mitigations were discussed and the risk score assessed which was uploaded onto the hospital's electronic risk register. All risks were discussed and updated at the hospital's board meeting, quality governance committee and MAC.

The surgical service had a local risk register which was reviewed monthly. Each risk was given a rating, review date, control measures and allocated with a risk owner. The issues and risks which managers identified were in line with what we found on inspection. There was 1 active risk for the department and 15 accepted risks. The main risk within surgical services was that a significant amount of equipment was at end of life and requiring replacement or modernisation. Mitigations were in place for these and managers as well as staff were able to explain these in detail. We were also notified of the service improvement plan, refurbishing initiatives, and ongoing business cases to ensure the risks were well managed.

The hospital had a risk dashboard which outlined risk status across the hospital to ensure risks could be monitored and updated continually and in real-time.

There was a formal audit programme for theatres and surgical wards. Heads of department and departmental audit champions discussed audit results and actions at monthly team meetings. Audit findings were also discussed at the theatre user group meetings. Results were shared at the monthly quality governance committee meeting and board meeting and quarterly MAC.

All learnings and actions from the audits were escalated to the corporate clinical audit and effectiveness committee and the quarterly clinical operations report meeting.

The service had appropriate emergency action plans for incidents such as power loss or fire. These outlined clear actions for staff to take and contact details of relevant individuals or services.

Information Management

The service collected accurate, valid, timely and 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.

Staff had access to patients' health records and the results of investigations and tests in a timely manner. The hospital used electronic systems which allowed the service to manage quality and compliance processes and ensure audit completion.

There were effective arrangements to ensure the confidentiality of patient identifiable data. Paper based patient records were stored securely in lockable cupboards at the nurse's station and electronic information was on a secure server which was only accessible by authorised staff members.

We observed staff logging off after using computers and staff reported that they had enough computer stations.

Staff commented that the IT system was user friendly and showed us they could easily find policies, learning modules and raise incidents on the hospital intranet and access various systems without issue.

Engagement

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

Patients were encouraged to share their views on the quality of the service through the patient feedback questionnaires. The service used patient feedback to guide the service delivery and responded to any concerns raised or suggestions made by people who used the service. Patient questionnaire results were consistently positive. Additionally, "You said, we did" boards were available on the wards and other clinical environments to demonstrate to patients and staff how the service had actioned their suggestions and concerns.

The hospital also had a patient experience group, made up of lots of different patients, to help improve patient experience of their care and treatment at the hospital. The hospital hosted a patient forum to provide all patients with the opportunity to have their voice heard. The forum could be attended in person at the Lister Hospital or attended virtually via a videoconference call.

Staff were engaged in the planning and delivery of the service. Staff told us they felt able to suggest new ideas to their managers and they were listened to.

We were told that The Lister Hospital had achieved a high staff engagement score. The latest staff survey results released in October 2023 from the vital voices employee survey, showed that within the surgical service 84% of the surgical team participated in the survey against an overall hospital participation rate of 68%. The overall engagement index was 70% which demonstrated a 67% favourability rating. Trends identified as actions included professional development opportunities, whilst accountability and team collaboration ranked high compared to the overall provider results.

There were several staff award and recognition programmes at the hospital for example: epic awards which managers could give to staff to recognise colleagues for their commitment and contribution to the hospital, daisy awards which were nominations of recognition made by patients, and the be exceptional everyday (BEE) award which was in place to recognise non-nursing staff.

The hospital had various staff engagement forums such as the colleague council and staff listening forums where all staff were invited to join.

Staff had access to an employee assistance programme that provided access to counselling, such as following an incident. There were mental health first aiders on site to provide additional support to staff.

The Lister Hospital had established a partnership with a leading private provider of cognitive healthcare. The provider offered preferential access to its multidisciplinary team of psychiatrists, psychologists, therapists, coaches, and other behavioural experts, to the patients and clients at the Lister Hospital.

The deputy chief nurse and lead for the rapid referral service (unplanned admissions) regularly went with the business development team to visit local GP's who referred into the service. This was aimed at understanding how the hospital could continue to improve on the services they offered to GP's and patients.

Members of the senior management team and clinical leads often met with other local health care providers to increase the understanding of how the hospital could support them in their work whilst also exploring how they can access services. As an example, the service regularly communicated with a local provider of tailored home care to facilitate access for patients.

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, entrepreneurialism and participation in research. Staff were actively participating in research and improvement projects.

Staff at all grades were committed to continuous learning. All staff we spoke with told us they were supported by their managers to develop their leadership skills and access development opportunities. The hospital offered e-learning, classroom courses and specialist training programmes for both clinical and non-clinical staff.

Staff were involved in various quality improvement projects. For example, The Lister Hospital undertook an analysis of falls across all inpatient departments (surgery and medicine) comparing data from 2021 and 2022. The service found that 61% of falls in 2022 were with patients under the care of surgical services. A working group was set up which led to the development of a specific reducing falls information leaflet for surgery. This leaflet, developed by The Lister team, was shared with all provider organisations and is now the standard leaflet to be used in all facilities. Other quality improvement programmes included the pre-operative pathway that supported patients to get the right care and information at the right time and prepare the patient for the post-surgical rehabilitation.

The service was entrepreneurial and innovative in their approach to women's care. The service was pioneering a treatment to help preserve fertility and delay the onset of the menopause. This technique was developed from the treatment of cancer patients and involved the removal of a small amount of healthy ovarian tissue which was then cryopreserved. The service worked closely with the Human Tissue Authority, leading clinicians, and researchers to be the first independent sector hospital to offer this treatment which could enable women to preserve fertility and postpone the menopause.

Staff commented on how they valued the various study days that they were able to take part in such as orthopaedic study days and learning sessions with the clinical nurse specialists. Other examples of learning included investing in additional training for surgical first assistants and research fellows to support with the increasing demand for robotic surgery.

The service was actively involved in research. We saw how the tissue viability clinical nurse specialist recently published a literature review on the use of acellular fish skin grafts in wound healing.

The service was active in trying to improve and respond to individual patient care needs. They had transitioned to a new outcome platform in which automated aspects of the outcome pathway to better capture patient outcomes. This new platform allowed accurate and timely feedback from patients and influenced their course of treatment at the time of reporting. The service called this 'in flight' patients reportable outcome measures.

The service worked as a team to innovate care. An example of this was the constant liaison between the pre-assessment team and anaesthetists to optimise all patients prior to admission. The whole team involved in the patients' care, from the medical secretaries to the catering staff, surgical schedulers, and allied healthcare professionals, articulated a consistent message to patients regarding their recovery and expected early mobilisation. Perioperative care was overseen by the consultant anaesthetist supported by a clinical nurse specialist and specialist physiotherapists.

Good

Urgent and emergency services

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

Is the service safe?

Good

We have not previously inspected urgent care. We rated it as good.

Mandatory training

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

Staff received and kept up to date with mandatory training. Training was comprehensive and met the needs of patients and staff. The provider had a standard training framework based on individual roles, such as for nurses and GPs. All staff completed core modules such as infection prevention and control (IPC), ethical treatment, and safeguarding.

Staff were empowered to manage their training needs and department leaders supported access to more advanced training if this was appropriate. For example, staff had access to higher education programmes and advanced clinical opportunities.

The department had increased focus on meeting the needs of patients living with mental health needs as well as recognising and responding to patients with learning disabilities, autism, and dementia. Staff completed training in line with the provider's policies and diversity framework. This provided staff with the skills to manage immediate patient need while waiting for the on-call psychiatrist or a transfer to a specialist service.

At the time of our inspection the team had 98% compliance with training requirements. As the team was relatively small, this reflected 100% completion for most staff in most subjects and there was a plan in place to achieve full completion in the near future.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. They gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act, and demonstrated a good level of knowledge.

Clinical staff completed adult and child safeguarding level 3 and patient access officers (PAOs) completed training to level 2. At the time of our inspection all members of the team were up to date with training.

PAOs were non-clinical staff responsible for reception duties, registering patients, and a range of administrative tasks. Their safeguarding training reflected good practice because it meant they could identify and act on safeguarding concerns while patients and those accompanying them waited to be seen by clinical staff.

The team demonstrated a good understanding of safeguarding risks and signs that would be cause for concern and how they would seek help. All staff had a good understanding of the provider's safeguarding leadership team, including how to contact them for support, including in an urgent situation.

The department provided discreet information for patients that enabled them to ask for private space to discuss concerns with staff as well as contact details for external specialist organisations.

The urgent care centre (UCC) did not routinely treat children and young people (CYP). However, staff maintained training and up to date safeguarding knowledge in recognition that children may accompany adults to the department.

All staff were trained to act as chaperones. Clinical staff followed the provider's standard operating procedure to secure a chaperone where they felt it was a safety need for the patient.

The provider had a range of safeguarding policies that guided staff and enabled them to access specialist information. This included for concerns relating to radicalisation, female genital mutilation, and human trafficking.

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 were clean and had suitable furnishings which were clean and well-maintained. The service performed consistently well for cleanliness.

Cleaning records were up to date and demonstrated that all areas were cleaned regularly. The hospital's dedicated housekeeping team carried out routine cleaning and disinfection. The clinical team request a deep clean or additional support after events such as a biohazard spill.

Staff followed infection control principles including the use of personal protective equipment (PPE). They used gloves and masks appropriately and followed good standards of hand hygiene.

Staff cleaned equipment after patient contact and documented decontamination as part of an assurance process.

Staff followed the provider's 'commitment to cleanliness' standard, which included colour-coding for cleaning products in line with national standards. The provider audited each department in the hospital on a rolling basis to benchmark standards of practice against expectations. The most recent audit rated the UCC a maximum of 5 stars.

The provider audited IPC standards using a comprehensive 25-point check including consistency and effectiveness of hand hygiene and correct use of PPE. The team had a track record of good performance, with 100% compliance in the previous 12 months.

Staff managed sharps in line with national standards. For example, sharps bins were labelled and stored safely. In the previous 12 months the department maintained 100% compliance with provider standards in a monthly audit.

Environment and equipment

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

The design of the environment followed national guidance, including adherence to the infection control requirements of the Department of Health and Social Care (DHSC). A centralised provider team managed compliance in the design and use of the various rooms in the department and staff escalated concerns or challenges.

All surfaces such as seats and examination beds were wipeable and reflected the latest DHSC standards in effective hygiene in clinical environments. Staff documented daily cleaning and the provider monitored compliance with expected standards.

The provider operated standards for processes such as the safe management and disposal of hazardous waste and water flushing to reduce the risk of Legionella build-up in taps. UCC staff followed provider policies and centralised teams audited standards. Audits demonstrated consistent compliance with the provider's policies.

The service had enough suitable equipment to help them to safely care for patients. The provider planned preventative maintenance on clinical equipment in advance to reduce the risk of interruption to care. Staff had access to on-call facilities and maintenance staff in the event of an equipment failure.

Staff disposed of clinical waste in line with the provider's policy. During our inspection staff handled and stored waste safely.

Staff used a stock control system to manage medical consumables and other products. Each room had a pre-determined stock range and staff displayed each, which helped those working shifts who did not often work in the department. This system meant the clinical team were always assured of access to adequate consumables.

The service performed consistently well in the provider's monthly health and safety audit. This included the management of environmental hazards and safe storage of equipment such as oxygen cylinders. In the previous 12 months staff achieved 100% compliance with expected standards.

While the environment was well maintained and provided good standards of safety in most areas, there were gaps in assurance for the mitigation of ligature risks. For example, there were multiple ligature points in the department with no risk assessment in place. Staff did not have access to a ligature cutter and said they would use plaster scissors to cut a ligature instead. The provider had not carried out a drill or training scenario of someone caught in a ligature. This risk was somewhat mitigated by an enhanced observation policy that meant if staff had identified an immediate mental health need, they would not leave a patient alone at any time. Staff were trained in the use of this policy.

Assessing and responding to patient risk

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

Good

Urgent and emergency services

Staff used the national early warning scores (NEWS2) tool to identify deteriorating patients and escalate them appropriately. The provider audited the use and documentation of NEWS2 and in the previous 12 months staff achieved 100% compliance with expected standards.

PAOs were the first team to meet patients on their arrival in the department. They undertook training to recognise patients who presented with emergency needs outside of the scope of the service. For example, if a patient had chest pain, severe bleeding, or disclosed suicidal intent, staff arranged for alternative emergency care.

A senior staff nurse triaged each patient on arrival and followed the department's standard operating procedure, to ensure the department was equipped to provide the care needed.

The department included a resuscitation room equipped with lifesaving equipment, which clinical staff were trained to use. This included a manual defibrillator, ventilator with a range of oxygen masks in different sizes, and emergency medicines. Staff kept the resuscitation room free for access at any time and did not use it for routine medical purposes. This meant emergency equipment was always available when it was needed.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly during their care. Risk assessments followed national guidance and included signs of sepsis and deep vein thrombosis. Staff were trained to identify the risk of sepsis and assess patients in line with the national pathway.

Staff arranged psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The team worked with specialists across other services in the region to secure the most appropriate support for patients, including those experiencing a crisis. For example, staff liaised with the local NHS mental health team when a patient disclosed suicidal intent, to ensure they received immediate care. While the service could provide immediate care to keep people safe and had an on-call psychiatrist in the hospital, additional arrangements meant staff could initiate specialist care before the patient was discharged. Such instances were rare and so no monitoring data were available. Instead the provider had implemented such processes as good practice in recognition of the risk a patient presented with acute mental health needs.

Handovers included all necessary key information to keep patients safe. Where a consultant made the decision to admit a patient, UCC staff clearly documented their initial assessment and care in the patient's record.

Staff had life support training at a level commensurate with their role. All non-clinical staff were trained in basic life support (BLS) and clinical staff held either immediate life support (ILS) or advanced life support (ALS) training. A clinician with ALS training was on duty in the hospital at all times the UCC was open.

A resuscitation lead was based in the hospital and worked with staff in each department to ensure they had up to date training, competencies, and access to the latest Resuscitation Council UK guidance.

Staff used evidence-based tools to manage patient risk. For example, the service had adapted the 'situation, background, assessment, recommendation' (SBAR) tool, more commonly used to assess incidents, to document handovers to ward staff when a patient was admitted. This was good practice because it meant receiving teams had a complete view of the patient's needs.

The UCC provided care and treatment to adults over the age of 18. However, staff were trained to provide paediatric life support in the event a child presented with a medical emergency, prior to the child being transferred out. The department maintained a stock of emergency medical equipment for children. In such an emergency staff would determine whether to call 999 or to transfer the child to the provider's paediatric UCC based on clinical need.

Staff had access to emergency transfer services in the event a patient needed to be moved to another hospital. This included a service level agreement with an intensive care ambulance provider.

The resuscitation team carried out annual simulation training with staff. This was an unannounced, practical scenario designed to test the team's response to a medical emergency. The most recent simulation found good standards of practice, with clinical response in line with expected actions and no areas for improvement.

In the previous 12 months, staff arranged for the emergency transfer of 1% of patients from the unit to an NHS emergency department (ED). Where patients had an urgent need for specialty treatment but did not meet the criteria to attend ED, staff provided an urgent referral to an appropriate NHS specialty on-call service.

Staffing

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

The service had enough staff to keep patients safe. The UCC team included a lead nurse, 3 senior staff nurses, 2 PAOs, a lead GP, and 3 core GPs. The provider's internal bank nurse system and 19 additional GPs across the organisation meant the unit was always fully staffed and could work flexibly to increase staffing during periods of high demand. Typical staffing levels were 1 PAO, 1 GP, and 2 nurses per shift. This was appropriate for the size of the service.

The staff team was stable and consistent, with very low levels of sickness and turnover in the previous 5 years at less than 0.5% in each measure.

All staff, including locum GPs, completed an induction programme. The provider's medical director shadowed a sample of consultations of newly appointed GPs to embed expected standards of care.

An on-call consultant was always available in the hospital when the UCC was open to provide support to GPs.

Records

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

Staff used paper records when patients first presented in the department. Once care had begun, they transferred information to the electronic patient records (EPR) system. While this system generally worked well, it was not evident staff always updated information where patients disclosed new details. For example, in 1 record a patient had initially told staff they had no allergies. However, they disclosed an allergy at the point of being prescribed medicine. Staff made a note in the EPR about the allergy but did not update the patient's information in the template of the record. This meant it was not immediately obvious to staff unfamiliar with the patient's needs that an allergy update had been made. We spoke with staff about this who said patients often did not always disclose allergies at the initial point of contact although there was not a system of assurance in place to manage this risk.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff in any department or hospital in the provider's network could access a patient's EPR. This was good practice because the service worked across multidisciplinary pathways, and it was often necessary for consultants to access diagnostics and assessments. Where staff referred a patient to an NHS service, they provided a detailed written handover and instructions to the patient to help them access the most appropriate service.

The provider's medical director carried out regular quality audits of GP clinical records using the Royal College of General Practitioners standards as a benchmark. This supplemented a monthly audit of nursing notes. The service performed consistently well, with over 99% compliance in all audits in the previous 12 months.

The EPR system had a flagging system that enabled staff to alert each other to specific needs or risks, such as patients living with dementia or with a known safeguarding risk.

Staff stored records securely. During our inspection staff locked paper documents in secure storage areas and followed good practice to protect electronic data, such as logging out of computers when they were not in use.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff completed medicines records accurately and kept them up to date.

Staff stored and managed all medicines and prescribing documents safely. The UCC maintained a stock of commonly used medicines and the hospital's centralised pharmacy team provided support for stock and dispensing.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. This was part of the handover process and GPs worked with receiving specialists to coordinate appropriate prescribing.

Staff learned from medicines incidents to improve practice. The team reported 2 medicines incidents in the previous 12 months. Both involved an error in dispensing. Patients did not experience harm as a result and in both cases the investigation highlighted learning for staff.

Staff completed daily medicine checks and supplementary checks of Controlled Drugs (CDs) in line with Home Office requirements. In the previous 6 months the department achieved 100% compliance with expected standards.

The provider's pharmacy team audited antimicrobial prescribing and updated staff with changes to best practice guidance. The pharmacy team audited medicines management quarterly and found consistently good practice, with 100% compliance in the previous 6 months.

Incidents

The service managed patient safety incidents well. Staff recognised and reported 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.

Good

Urgent and emergency services

Staff knew what incidents to report and how to report them. They raised concerns and reported incidents and near misses in line with provider policy.

In the previous 12 months staff reported 25 incidents. None of the incidents resulted in patient harm and the team reviewed each to identify themes or trends. In each case staff worked together to identify areas for improved practice.

Staff understood the duty of candour and completed training as part of a wider medical ethics standard. In the previous 12 months, the service reported no incidents that fell within the provider's threshold for a duty of candour response, although staff apologised and discussed findings with patients in each case.

There was evidence that changes had been made as a result of learning from incidents. For example, 1 incident involved a laboratory sample that could not be tested because staff used an incorrect sample tube. As a result, the team updated and improved the process for sending samples.

Staff investigated incidents thoroughly as part of the provider's clinical governance processes. The team had a demonstrably inquisitive nature and proactively sought learning opportunities. They considered the policies and procedures of other organisations to support the implementation of change after an incident. For example, GPs worked with colleagues at a local NHS trust to improve the ambulatory care pathway after an incident that involved a missed diagnosis. The patient was not harmed as a result and the learning reflected good practice from effective reviewing of records and patient outcomes.

Is the service effective?

Good

We have not previously inspected urgent care. We rated it as good.

Evidence-based care and treatment

The service provided holistic care and treatment based on national guidance, evidence-based practice, and research. Managers checked to make sure staff followed guidance and provided support for improvement.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance such as that issued by the National Institute for Health and Care Excellence (NICE) and the Royal College of General Practitioners (RCGP). The team continuously sought good practice examples against which to benchmark care and treatment, such as in the appropriate use of radiology diagnostics and sepsis assessments.

The provider had a comprehensive programme of audit and benchmarking that aimed to provide staff with assurance of standards of practice. While data demonstrated patients received quick treatment, the provider benchmarked against acute emergency departments, which had a different case mix and could be compared to the type of care provided in the urgent care centre (UCC).

At handover meetings, staff routinely referred to the psychological and emotional needs of patients. Handover documents, such as to inpatient ward staff or NHS services, showed staff considered each patient's holistic needs beyond their immediate medical presentation.

Staff used the provider's electronic document library to access policies and standard operating procedures (SOPs). The provider managed policies and SOPs to ensure staff reviewed them at appropriate intervals, including after a change in national guidance or after learning from an incident. Urgent care centre (UCC) staff contributed to departmental policies and worked as a team to make sure guidance reflected the scope and nature of the service.

All staff had ready access to policies and SOPs and understood how they directed and impacted care. Where a patient's needs fell outside of policies, staff worked together and with specialists across the provider's network to identify appropriate standards of care.

Staff collaboratively sought assurance and validation of their practice and care through a comprehensive programme of audits. For example, the team audited their use of clinical escalation pathways and adherence to standards of the national early warning scores (NEWS) tool. In the previous 12 months audits demonstrated 100% compliance with provider and national standards.

The provider had an expectation of 100% compliance with audits; this was a standard across all services and departments. Where audits found less than 100% compliance, staff prepared action plans for improvement.

Clinical staff used a newsletter to share learning and outcomes, such as from a recent audit on the management of sore throats.

The service monitored the medical presentation of each patient to identify trends and themes in demand. For example, orthopaedics was a key specialty reflected in patient's needs. The team used this data to drive their training and professional development and to establish working agreements with consultants in the hospital.

Nutrition and hydration

Staff ensured patients were hydrated whilst in the department.

Patients typically attended the UCC for short periods of time and did not need food or nutrition. However, the service was equipped to respond to patients who were malnourished or who spent extended periods in the department. They had access to the hospital's hospitality team who could provide a wide range of meals to meet dietary and cultural requirements, including for patients in need of specialist nutrition.

Patients had access to drinking water and hot drinks whilst in the UCC and staff provided rapid rehydration where clinically indicated.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. This reflected the nature of the service and staff understood a key need for attending the department was often pain relief. Policies and practice reflected this, and staff offered patients pain relief during triage, which typically took place in less than 15 minutes after arrival. Staff had access to communication tools to support patients living with learning disabilities, dementia, and mental health needs.

Patient access officers (PAOs), who were usually the first team to meet a patient, asked about pain during their initial registration process and escalated concerns to the triage nurse.

Nurses used patient group directions (PGDs) to administer pain relief during triage after assessment. PGDs allow non-prescribers to administer specific medicines to patients under pre-defined conditions. The provider checked adherence to this policy during their monthly audit.

The provider audited compliance with expected standards of pain relief, using 9 key checks, such as an initial pain assessment for each patient. In the previous 12 months staff achieved 98% compliance with expected standards.

Patient outcomes

All staff actively monitored the effectiveness of care and treatment through continual, extensive assessment processes. They used the findings to make improvements and achieved good outcomes for patients that consistently exceeded expectations.

Outcomes for patients were positive, consistent, and met expectations, such as national standards. Staff used the results to improve patients' outcomes. Clinical and non-clinical teams worked together to refine the patient admission and registration SOP. This followed previous instances of the service accepting patients outside of the scope of care. The process resulted in improved outcomes for patients as they received the right type of care and treatment at their first point of contact.

The team performed consistently well in sepsis management, with 100% compliance against all gold standards in the previous 12 months.

Staff provided printed or digital information for patients to help manage a diagnosis or condition that required care after they left the UCC. This included information on managing plaster casts and what to do in the case of an accident or unexpected side effect.

Staff monitored patient outcomes using an in-depth auditing tool that included the medical specialty of onward referrals and the number of patients who were admitted for secondary treatment. In the previous 12 months an average of 5% of patients were admitted to inpatient care.

Staff completed a programme of medical ethics training. This enabled the team to work effectively with patients who presented with diverse cultural needs and religious beliefs in the context of private self-paid care.

The team were empowered to develop research and programmes of work aimed at improving patient outcomes. The service used a remote radiology system that enabled patients to access imaging results through an online portal. This enhanced patient engagement with recovery and good health and enabled staff to work more closely with them to promote good outcomes. The system avoided duplication of diagnostic scanning and reduced unnecessary radiation exposure when patients attended secondary care for onward treatment.

The point of care testing laboratory in the department enabled staff to provide immediate diagnostics without the need for patients to attend different departments.

Competent staff

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

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. All staff completed a full induction tailored to their role before they started work. This included a corporate induction at provider level and a departmental induction focused on the work of the UCC.

Managers supported staff to develop through yearly, constructive appraisals of their work. At the time of our inspection all staff were up to date with their appraisal. The provider had a standardised system of appraisal across all teams and departments. This meant the senior team were assured that any locum or bank staff working in the clinic had undergone an annual appraisal.

The UCC had a supervision structure that reflected the small nature of the team. Each nurse had a monthly 1-to-1 meeting with the lead nurse as part of the wider culture of staff development. This enabled immediate feedback, support, and learning across the team, which contributed to an environment of support and collegiality. Supervision records were personalised to the individual member of staff and the team told us the process led to opportunities for continuing professional development.

Staff completed training through a combination of e-learning self-study and practical training, managed through a learning academy system. Staff said this worked well and they received protected time for training and study. The team had recently tested their skills when a patient suffered a cardiac arrest in the department and when the department was evacuated due to a fire alarm activation. In each case the lead nurse and GP carried out a debrief with the staff involved and shared learning and outcomes.

The learning academy system allowed staff to record cross-role training to expand their responsibilities in the UCC. For example, after training staff could list themselves in supplementary roles such as fire marshal, Nursing and Midwifery Council assessor, and clinical team leader.

In addition to the provider's internal training, staff had access to a wide range of specialised development delivered by external professional agencies. For example, staff were undertaking grief, loss, and bereavement training with a mental health provider in addition to mental health crisis training.

UCC staff were trained to provide the various services in the department, including point of care testing and plaster casting. The hospital's point of care testing team provided on-demand support for laboratory work beyond the scope of the department.

The provider supported staff to develop their academic credentials and to build knowledge and skills through extended professional development. For example, nurses had access to Masters-level study and support to undertake advanced nurse practitioner training.

Specialist consultants regularly joined weekly GP meetings to present education sessions based on case studies and multidisciplinary working.

Each registered nurse had a designated reviewer for revalidation with the Nursing and Midwifery Council (NMC). This meant nurses were always prepared for revalidation and the provider was assured of consistent staffing.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals were dedicated to collaborative working to benefit patients. They supported each other to provide consistent, joined-up care.

Good

Urgent and emergency services

Staff worked across health care disciplines and with other agencies to care for patients, including when patients presented with needs beyond the scope of the UCC. This included patients who presented with emergency or mental health needs. GPs referred patients to consultant physicians in the hospital for onward specialist diagnostics and treatment following initial review and pain relief in the department.

The hospital had a team of on-call consultants covering each medical specialty. The UCC service worked with consultants to review patient needs and discuss onward treatment. Where the hospital did not have the required specialist, staff referred patients to other hospitals in the provider's network or to NHS services on request.

The consultant on call in the hospital was responsible for making the decision to admit once the patient had been referred by the UCC doctor. Teams worked together to agree a care plan before the patient was admitted. This process was multidisciplinary by nature and included a review by the resident medical officer (RMO) and the nurse duty manager. A clinical nurse specialist worked across the provider's hospitals in London and provided on-demand specialist support. Staff said they were readily accessible and often provided ad-hoc teaching and coaching.

Systems were in place to ensure patients received multidisciplinary care, including in urgent situations. For example, where a patient presented with complex mental health and pain needs, staff coordinated a multidisciplinary review that included specialists external to the provider. Case notes of multidisciplinary referrals and liaison were detailed and demonstrated good standards of practice.

The provider had a range of service level agreements with other providers that enabled staff to access specialist care, such as to high dependency units outside of the provider's own network and a consultant microbiologist.

The lead nurse and lead GP had implemented a new digital handover system as part of a programme of digital transformation. The new system enabled staff to provide more efficient handovers to colleagues when a patient was admitted for specialist care.

Multidisciplinary care pathways demonstrably resulted in good outcomes for patients. For example, the rapid point of care testing available in the UCC combined with joint clinical assessment with radiology, colorectal surgery, and haematology resulted in successful treatment for a patient who presented with a very rare undiagnosed condition.

In addition to emergency and NHS referral processes, the provider operated a fast-track consultant appointment service that meant GPs in the UCC could secure appointments within the provider's network, usually on the same day, for patients who required secondary care.

Seven-day services

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

The service opened 7 days per week, including bank holidays, from 8am to 8pm. The service accepted the last patient at 7pm, which ensured clinical support services were available in house for the duration of their stay.

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support was available in the department and digitally.

Good

Urgent and emergency services

Staff provided up to date contact information for services that provided specialist support for people experiencing domestic violence. This included an organisation specialising in men's health and another offering support for lesbian, gay, bisexual, transgender and queer (LGBTQ+) people. Information was available in different languages and was posted discreetly in private areas so that people could access details without being noticed.

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.

All care was elective, and patients sought treatment on a walk-in basis. They signed a consent form as part of the registration process, which included whether they consented to staff sharing details of care and treatment with their usual GP.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff received and kept up to date with training in the Mental Capacity Act. The UCC provided medical care to patients who could fully consent to their own treatment. Where staff found a patient did not understand their care needs or planned treatment, or could not provide consent, they liaised with the duty psychologist in the hospital for support.

Staff maintained up to date guidance to help provide effective care and communication to patients living with dementia. While the team said this was a rare occurrence, they were prepared to provide care and had access to specialist resources to do so.

Is the service caring?

Good

We have not previously inspected urgent care. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed attentive, compassionate care during our inspection.

The provider facilitated an ethos of individualised, inclusive care, and provided staff with training and resources to address individual needs as they saw fit.

Staff were well versed in the diverse needs of patients, including in relation to culture, religion, gender, and sexual identity. This included providing support to patients who wished to make clinically unwise decisions.

Staff proactively asked patients for feedback after appointments and feedback was consistently positive. Recent comments included, "I felt welcomed," and "Staff were professional, friendly, and caring."

Good

Urgent and emergency services

In the previous 12 months, 100% of patients who completed a feedback card said staff had treated them with privacy, respect, and dignity.

Emotional support

Staff provided emotional support to patients, families, and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. The team recognised patients sought care in urgent circumstances that could interrupt their usual daily routines and commitments. They delivered care aimed at restoring each patient's plans or routine.

During our inspection staff spoke to patients with genuine kindness and understanding.

Staff undertook training on breaking bad news and discussed how they would demonstrate empathy when having difficult conversations. This was a rare occurrence given the nature of the clinic and staff sought more advanced development opportunities to ensure they were always prepared. For example, the team was undertaking grief, loss, and bereavement training to help enhance care provision.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. They talked to patients in a way they could understand, adapting their communication to each individual.

Feedback from the patient survey was positive and in the previous 12 months, 100% of respondents said staff had involved them in decisions about their care and communicated clearly. A recent patient commented, "I felt informed of the process [and] involved with the diagnosis process and decision to request an x-ray."

During our inspection staff worked collaboratively with patients to make sure they were part of care and treatment decisions.

Is the service responsive?

Good

We have not previously inspected urgent care. We rated it as good.

Service delivery to meet the needs of local people

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

Staff planned and organised services, so they met the needs of people accessing the service. This included monitoring the types of care for which patients attended, predicting peak times for demand, and working with medical specialties to facilitate inpatient admission and outpatient access.

Facilities and premises were appropriate for the services being delivered. Patients had access to quiet, private spaces on request and the department was equipped to provide treatment for a range of illnesses and injuries.

The provider operated a medical concierge service for patients normally resident outside of the UK, such as embassy staff and tourists. The urgent care centre (UCC) team worked with colleagues to provide rapid access to private GP services, alongside the provider's rapid referral service, which facilitated access to specialties elsewhere in the provider's hospital network.

The team helped patients access outpatient specialists within 24 hours. Patients could choose the subspecialties of consultants through the provider's online booking system.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities, and dementia, received the necessary care to meet their needs. They had training and resources to provide adapted communication and clinical assessment tool to ensure they met individual needs. For example, staff used a hospital 'passport' to support patients with cognitive and communication needs. The hospital had a dementia and learning disability lead nurse and staff contacted them on demand to support patient care.

Staff met the communication needs of each patient. The clinic was equipped with a hearing loop and visual communication cards as part of a range of communication support aids, which staff were trained to use. Such resources meant patients with conditions such as hearing loss, learning disabilities, or dementia, could more readily access the service. Staff completed training as part of the provider's learning disability and autism awareness framework and had access to more specialist support on an on-call basis. The service provided information in a range of different formats to meet patients' needs. This included Makaton signage and large print material.

The service had information leaflets and digital information available in several different languages. Posters in the clinic, including for safeguarding concerns, included information in the most commonly spoken languages staff encountered in addition to English. They could secure translators by telephone on demand and arrange in person translators based on availability at the contracted organisation. The wider hospital team represented a range of nationalities and staff could often source language support internally.

Staff completed cultural competency and unconscious bias training to help them recognise patients with specific needs and influences on their decision-making. This was part of a broader programme aimed to ensure patients from all backgrounds could access barrier-free care.

A psychologist was available in the hospital on an on-call basis while the UCC was open. Staff knew how to contact them, including in urgent circumstances.

Staff supported patients to access onward care by providing information to help them navigate and access services. For example, they provided written instructions to a patient about where to find a department in an NHS hospital after their UCC assessment found a need for further investigation.

Good

Urgent and emergency services

As part of a wider programme of tailoring care to individual needs, UCC staff were trained in transgender diagnostic medicine, which meant these patients received expert, highly effective care.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times for treatment and arrangements to admit, treat, and discharge patients were minimised.

The UCC standard for the time from arrival to triage was 15 minutes, which the team met in 95% of cases.

Staff collected each patient's NHS number, where they were a UK citizen, at the first point of contact. As patients had the choice to remain with this provider or be referred to NHS secondary care if further treatment was needed, the information supported a smooth referral.

Many patients sought urgent care while away from home or their usual place of residence. The service requested temporary and permanent contact details as part of registration, which enabled them to remain in contact to discuss test results or future onward referrals.

The UCC provided care to patients aged 18 years and over. The provider's website provided details of urgent care provision for children and young people and staff redirected this patient group when they presented in the department.

Arrangements were in place to provide care for patients still in the unit after it closed. The service stopped accepting walk-in patients at 7pm each day and staff were rostered to work until 8pm. Where they could not discharge a patient due to medical need, they liaised with the hospital's nurse duty manager and arranged for a 'decision to admit' assessment.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

The service clearly displayed information about how to raise a concern in patient areas and on their website. Staff understood the policy on complaints and knew how to handle them.

The service had not received any formal complaints and staff were trained to deescalate minor concerns raised by patients when they were in the UCC.

The provider subscribed to the independent sector complaints adjudication service (ISCAS) and provided their contact information as part of the complaints policy.

Is the service well-led?

Good

We have not previously inspected urgent care. We rated it as good.

Good

Urgent and emergency services

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 lead nurse and lead GP were responsible for the day to day running of the urgent care centre (UCC). The hospital's deputy chief nursing officer and medical director provided senior leadership and duty consultants supported the clinical team.

Staff described a 'flat hierarchy' in the department and said they worked as a collaborative team as peers. This was reflected in the provider's approach to training, which meant each member of staff could take the lead in emergency scenarios such as evacuations or a cardiac arrest. This approach provided continuity on each shift. The lead nurse and lead GP had overall responsibility and provided operational and clinical leadership with support from the provider's leadership team.

The provider supported staff to complete advanced leadership training, including at accredited academic level. For example, the lead nurse was undertaking an Executive Masters in Leadership and Management and the clinical lead was undertaking an Executive Masters in Business Administration. This reflected an ethos of empowerment and investment in leadership development.

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 provider had an overarching vision and strategy that applied across all its hospitals and departments. The UCC team had a clear understanding of, and commitment to, the vision and worked to apply them to the care they provided. For example, the team had implemented new evidence-based monitoring of patient outcomes to improve standards of care.

The team recognised most patients attended the UCC only once and when they were worried about a health condition. The team reviewed feedback continuously to identify opportunities to improve care and communication. This reflected the team's approach to embedding patient engagement and involvement.

There was a consistent focus on exceeding patient expectations and developing staff through a comprehensive programme of educational and professional development.

Please see the surgery report for more details.

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 staff could raise concerns without fear.

The UCC team worked closely together and had a demonstrable ethos of open communication, mutual support, and transparency. Staff said they felt listened to by the senior team and were empowered to raise concerns without fear of reprisal, which they felt confident would be acted on.

The provider operated a wide range of benefits and support packages for staff and the UCC team said they felt motivated and empowered as a result. Details of 2 peer-led recognition and reward schemes were displayed in the department, reflecting a culture of respect and appreciation between the senior leadership team and staff at all levels in the department.

The provider carried out a patient safety culture survey amongst staff to help understand how staff perceived safety and risk in the hospital. Results were pending at the time of our inspection and the activity reflected a risk-averse environment.

Staff had access to mental health first aiders, accredited by Mental Health First Aid England, for wellbeing and psychological support.

The provider promoted an environment that valued diversity and empowered staff, to ensure they worked inclusively with each other and patients. Staff participated in a range of events to embed inclusivity in their work. the provider encouraged staff to suggest event sponsorships and to arrange celebrations in line with different cultural or religious holidays.

The provider encouraged staff to speak up, challenge, and intervene as part of a culture of collaborative problem solving. Staff said they felt respected in the most recent staff survey and the department performed much better than the provider's average for how staff felt about communication and resources.

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.

Lead UCC staff joined the hospital's acute medicine and unplanned admissions group monthly review. This included a rolling programme of clinical reporting and meeting minutes that indicated a good standard of follow-up with actions, decisions, and incidents. The group reviewed demand on the department, which included the medical nature of needs, the number of patients admitted as inpatients, and other data that helped to plan and structure the service.

Clinical staff met monthly to review patient outcomes, changes in national or provider policy, and learning from incidents or feedback. The provider supplemented the meeting structure with a newsletter of changes that affected the hospital, such as updates to antibiotic prescribing guidance.

The provider's medical director carried out a quality review of all GP consultations and provided detailed feedback on the delivery of appropriate care. GPs spoke highly of this system and said it contributed to continuous improvement and the establishment of good clinical standards.

Governance processes were operated at provider level with input and engagement from each department. For example, UCC staff attended the medication management committee to discuss and review prescribing practices. The governance structure included 2 quality and safety boards, 1 at provider level and 1 at hospital level, and 6 overarching governance structures that included various committees and working groups.

GPs attended quarterly medical advisory committee (MAC) meetings and represented the needs of the UCC.

Governance processes with partner organisations focused on patient outcomes and ensuring the scope and range of services met patient need. For example, the service worked with an external mental health specialist provider. This arrangement included shared governance processes to ensure access and information sharing met both organisation's standards.

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.

The senior team used a key performance indicator (KPI) dashboard to monitor the performance of the UCC. KPIs were based around national quality indicators for emergency departments. While this meant the provider could not benchmark this service, the process helped establish times to treatment.

While the provider supported staff to work extra hours above their contract if they wished, the senior team recognised the risk of burnout from working excessively. The electronic staff rota system alerted staff where their planned hours exceeded usual safe limits The senior team worked with each individual to discuss managing wellbeing and achieving a good work-life balance.

The provider had business continuity plans for unexpected events such as floods or power failure. The nature of the UCC meant patients could not be treated elsewhere in the hospital and instead staff would redirect them to another urgent care facility within the provider network or to an NHS service.

Staff used a departmental risk register to mitigate potential interruption to the service or harm to patients. At the time of our inspection the department had 4 risks with mitigation in place and noted no live risks that required immediate action. However, the risk register did not identify ligature points as risk, which reflected a need for a more comprehensive understanding of environmental risks.

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.

Staff at the point of entry to the UCC provided patients with clear, transparent information on costs of treatment and the process of assessment, care, and onward referral.

Staff used the provider's bespoke cloud-based IT system that was standardised and managed centrally. This meant staff who worked across different departments used systems with which they were familiar and reduced the risk of data errors. The department was part of the provider's UK-wide digital transformation programme that aimed to streamline auditing, benchmarking, and quality improvement through a centralised system.

The service was committed to developing healthcare metrics as a strategy to drive continuous improvement. This included benchmarking against national standards and building on internal specialisms to ensure staff could meet individual needs.

The provider managed digital information systems to ensure they were secure and had back-up systems in the event of failure.

Good

Urgent and emergency services

Engagement

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

There was an overarching ethos of transparency between the provider, department, and patients. The waiting room and patient areas included information on the department's performance in areas such as cleanliness and customer service.

Staff encouraged each patient to complete a feedback card after their treatment, which rated the service using various measures of care and experience. In the previous 12 months, 93% of patients who completed feedback said they would recommend the service.

Please see the surgery report for more details.

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.

Results from the most recent staff survey highlighted members of the team wanted more guidance on progressing to senior roles in the organisation. In response, the provider arranged quarterly presentations by members of the senior leadership team about their career journey and experiences to date.

The provider encouraged participation in research that aimed to improve staff working conditions or patient outcomes. For example, the lead GP had worked with the human resources team to develop research, with staff engagement, to improve morale, which led to a consistent drive amongst the team to exceed patient expectations.

The lead nurse and lead GP had completed a digital transformation programme that streamlined care documentation processes, such as by implementing a new digital handover process. The team piloted and tested new initiatives before final launch to ensure they met the needs of the department.