Circle Health Group Limited

Mount Alvernia Hospital

Inspection report

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Date of inspection visit: 01 February 2022
Date of publication: 11/04/2022

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

Ratings

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

Summary of findings

Overall summary

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

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff 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 in the surgical and medical areas and six days a week in outpatients and diagnostic imaging.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However;

- In outpatients actions found from the most recent IPC standard precaution audit (November to December 2021) needed to be implemented to improve recent performance.
- Magnetic resonance imaging (MRI) referral paperwork for scans did not always have completed safety information and there was not a mechanism for the department to identify this prior to a patient appointment.
- Chairs in the positron emission tomography-computerized tomography (PET-CT) clinical rooms were not safe and required replacing.
- The diagnostic imaging department did not have a documented oversight of pharmacy activities when renewing medications.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

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

Diagnostic imaging

Good

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

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service-controlled infection risk well. Staff acted on risks to patients and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care to patients and monitored their pain. 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 six days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for a diagnostic procedure.
- Leaders ran services well, using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and

Summary of findings

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

However,

- There was not a mechanism or audit process that ensured information on referral forms is fully completed before a patient attended the department.
- Chairs in the molecular imaging clinical rooms were not safe and require replacing with a timeframe for action.
- The department did not have a documented oversight of pharmacy activities when renewing medications.

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

Medical care (Including older people's care)

Good

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

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.

Summary of findings

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

Medical care forms a main part hospital activity alongside surgery. Where arrangements were the same, we have reported findings in the surgery section.
We rated this service as good because it was safe, effective, caring, responsive, and well-led.

Outpatients

Good

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

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learnt lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care to patients. Managers checked 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. Services were available six days a week.

Summary of findings

- 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 gave emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for a diagnostic procedure.
- 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. Leaders focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients.

However,

- Actions found from the most recent IPC standard precaution audit (November to December 2021) need to be implemented to improve recent performance.

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

Summary of findings

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Summary of this inspection

Background to Mount Alvernia Hospital

Mount Alvernia Hospital is an independent hospital which is part of the recently rebranded Circle Health Group Limited. It is situated in Guildford, Surrey. Approximately 10% of patients are provided care through the NHS and all other patients are privately funded. The hospital provides care for adults aged 18 and over.

At the time of inspection Mount Alvernia Hospital was using two surgical wards with 25 beds, most of which are private rooms with en-suite bathrooms. There was an additional ward which was not in use. The hospital has three operating theatres an ambulatory care unit which included a six bay endoscopy suite, endoscopy theatre and a minor operation theatre and consultant rooms.

Mount Alvernia Hospital also had an oncology ward which had nine patient bedrooms, six pods and two consultation rooms.

The Imaging department offers magnetic resonance imaging (MRI) scanning, x-ray, positron emission tomography (PET), computerized tomography, nuclear medicine, Dexa scanning, ultrasound and digital mammography

Mount Alvernia is regulated to carry out the following actives:

- Diagnostics and screening
- Treatment for disease, disorder or injury
- Surgical procedures
- Family planning

The current registered manager has been in post for eight years. Mount Alvernia was last inspected in July 2016 and rated good overall. We inspected Mount Alvernia Hospital using our comprehensive inspection methodology. We carried out a short notice announced inspection on the 1 February 2022. On this occasion, we inspected surgery, medical care, diagnostic imaging and outpatients using our comprehensive inspection methodology.

The hospital provides day case surgery, inpatient surgery and cancer treatment services. The service offered a range of different surgical specialties, including orthopaedic, ophthalmology, urology, gynaecology, and ear, nose, and throat (ENT).

Activity (February 2021 to January 2022):

• There were 7523 day and inpatient admissions to the hospital; of these, 7.9 % were NHS funded.

• The top two surgical specialities were orthopaedic 1371 procedures and gynaecology with 411 procedures.

• There were around 3000 day case Systemic Anti-Cancer Therapy (SACT) episodes between February 2021 to January 2022 and between 60 and 90 endoscopy procedures each month under medical care.

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

Summary of this inspection

How we carried out this inspection

During the inspection visit, the inspection team:

- Assessed and visited all areas of the hospital including the surgical wards, theatres and recovery areas. We also inspected the ambulatory care unit which included the endoscopy theatre, oncology department, reception and all outpatient and diagnostic imaging areas.
- Reviewed the overall governance processes for the hospital and reported this as part of the well-led domain.
- Spoke with 43 members of staff including senior leaders, managers, doctors, pharmacists, nurses, allied health professionals and support staff, and 12 patients.
- Observed patient care and procedures with their consent, looked at patient waiting areas and clinical environments, and attended staff huddles and handover meetings.
- Reviewed 16 patient care and treatment records, five incidents, two complaints and several compliments.
- Looked at a range of hospital policies, procedures and other documents relating to the running of the services.

After the inspection visit, the inspection team:

- Reviewed further service information such as performance, training compliance, audits, policies, feedback from patients and staff.

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:

- Infection prevention and control practices across the hospital were highly effective and embedded. There was a team of motivated leads and link practitioners who promoted IPC practices and innovative implementation.
- The surgery service implemented the 'Don't Wait, Escalate' initiative which was a simple guide staff used to escalate serious concerns to managers in a timely manner to protect patients.
- The 'Think Drink, Sip and Send' initiative was based on the most recent evidence about pre surgery hydration methods. Research had shown that patients who were well hydrated recovered well and could be offered sips of water up to the point they left the ward for surgery.
- The systemic anti-cancer treatment service had ready made up packs for use in the event of specific clinical needs such as neutropenic sepsis and vascular occlusion which meant staff could react promptly and confidently in the event clinical emergencies.
- The oncology nursing team identified lower SACT infusion rates would reduce patient deterioration. Following a successful pilot, the team created SCAT rate charts to manage and monitor outcomes effectively. Results had been shared with other Circle Health Group oncology centres across the UK.
- There was a culture of quality improvement, staff were encouraged report concerns and make recommendations for improvements, which they were involved in implementing.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations.

Summary of this inspection

Action the hospital 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 MUST take to improve:

- The service must ensure that a clear mechanism or audit process that assures that information on referral forms is fully completed before a patient attends the department. (Regulation 12 (2) a, b)

Action the service SHOULD take to improve:

- The diagnostic imaging service should consider that the chairs in the PET-CT clinical rooms are replaced with a timeframe for action.
- The diagnostic imaging service should ensure documented oversight of pharmacy activities when renewing medications.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are Surgery safe?

Good

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

Mandatory training

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

Nursing staff received and kept up-to-date with their mandatory training. Staff received email reminders to complete training online and managers monitored compliance. Compliance rates were 99% for surgical ward nursing staff and 100% for theatre staff.

Medical staff received and kept up-to-date with their mandatory training. Surgeons and Anaesthetists completed their training whilst undertaking their NHS responsibilities and submitted the evidence to the providers Medical Advisory Committee (MAC). The MAC monitored compliance and sent reminders to staff when training was due to expire.

The mandatory training was comprehensive and met the needs of patients and staff. The digital training system listed over 15 training modules; these contained expected completion dates. When training was overdue the system highlighted the module in red.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia. Staff completed online training on mental capacity, deprivation of liberty and caring for patients with dementia. Also, on training study days managers embedded training by discussing scenarios to help staff identify and review patients.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers accessed their departments mandatory training compliance online. Clinical staff received email updates from the training database at regular intervals, to factored training into staff rosters. Staff told us that managers supported them to complete 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.

Nursing staff received training specific for their role on how to recognise and report abuse. Our last inspection identified gaps in safeguarding training. As a response to our concern's leaders identified key staff who completed safeguarding adults' level 4 training. This meant managers were qualified to deliver training, make decisions, and make sure staff completed safeguarding referrals correctly. Nursing staff received level 2 safeguarding training; completed online. Training included identification of female genital mutilation, modern slavery, domestic violence, and mental capacity.

There was a lead for safeguarding who was available to support staff at all times via the hospital senior manager on-call rota. The director of clinical services was also the safeguarding lead. Staff knew who they were and how to contact them.

Medical staff received training specific for their role on how to recognise and report abuse. Surgeons and anaesthetists completed mandatory training whilst undertaking their NHS responsibilities and submitted the evidence to the providers Medical Advisory committee (MAC). The MAC reviewed compliance on an annual basis at their annual appraisal.

Key managers had a process for safeguarding supervision. Managers discussed safeguarding scenarios during mandatory study days so that they shared learning with staff providing care to embed their knowledge and skills and records confirmed this.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. We found a positive safeguarding culture. Staff throughout the unit were "safeguarding aware" and gave us numerous examples of what situations may lead to a safeguarding referral.

Staff knew how to identify adults at risk of, or suffering, significant harm and worked with other agencies to protect them. The safeguarding lead reviewed referrals and worked with other agencies to protect people. The lead attended a safeguarding forum on a regular basis held at the local clinical commissioning group, where safeguarding leads for the area explored themes and discussed strategies to reduce risk. Outcomes were fed back to staff who raised concerns.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff accessed safeguarding referral forms online, managers helped staff complete the referrals to ensure the forms included all the relevant patient details.

Cleanliness, infection control and hygiene

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

Theatres and ward areas were clean and had suitable furnishings which were clean and well-maintained. Housekeeping staff supported clinical staff with cleaning. Housekeeping staff completed cleaning check lists and signed for them daily, managers displayed them in key areas. The service manager monitored cleaning audits and outcomes reported to staff via the daily update. Service managers arranged deep cleans of theatres every four weeks.

The service performed well for cleanliness. The providers guidelines reflected national Infection Prevention Control (IPC) guidance from Public Health England (PHE), and the Royal College of Surgeons. Staff completed bimonthly infection control audits. These included patient equipment, standard precautions, non-touch techniques, hand hygiene, bare below the elbows and the safe disposal of sharp objects. Also, staff completed body temperature audits in each department. The most recent audit confirmed the service performed well, the average performance was 95% from January 2021 to January 2022.

Good

Surgery

Staff used records to identify how well the service prevented infections. The IPC lead used data to inform future training and update staff newsletters. For example, the IPC lead arranged chain of infection awareness, glove awareness week and e-learning on clinical assessments.

Patients completed a Covid-19 questionnaire and prior to their appointment staff called patients to make sure they did not have any symptoms of the virus. The hospital displayed social distancing posters throughout the hospital and hand sanitiser was available in all areas.

Staff followed infection control principles including the use of personal protective equipment (PPE) as outlined in the services PPE standard operating procedure. The provider made PPE available to all staff in all departments. Staff always wore masks. Staff caring for patients wore gloves and aprons, they received training to 'don and doff' a term used to put on and take off PPE that minimises the risk of contamination. Staff completing aerosol generating procedures were 'fit' tested to ensure they were the appropriate mask.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. All equipment not in use, clearly displayed 'I am clean' stickers. Sterile packs used for surgery were stored in appropriate areas and not opened until required. Staff sent used surgical instruments off site for deep cleaning by a third party organisation.

Staff worked effectively to prevent, identify and treat surgical site infections. The IPC lead completed surgical site infection monthly reports for the corporate team to review. The provider submitted surgical site infection data to PHE on a quarterly basis.

Staff recorded abnormal microbiology results on the providers electronic incident reporting system which alerted the IPC lead. The IPC lead reviewed and investigated all incidents and discussed results with the pharmacist to ensure patients received the correct antibiotic treatment.

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. Since our previous inspection, the provider had made large investments to replace flooring, update ward bedrooms and install or replace hand wash basins in all areas.

Patients could reach call bells and staff responded quickly when called. Call bells were positioned by patient beds and staff showed patients how to use them to summon help.

Staff carried out daily safety checks of specialist equipment. Shift leads allocated emergency lifesaving equipment checks at the beginning of each shift. Staff completed and signed a check list. Managers monitored compliance to the completion of safety checks via monthly audits.

During the inspection we noted that an airways trolley did not have the correct safety seal which approves the items as sterile and checked. We raised this with staff and the manager who immediately checked the trolley and made sure the trolley was resealed.

Good

Surgery

The service had suitable facilities to meet the needs of patients' families. All rooms were single occupancy. This meant that during non-Covid times patients families visited in private and comfort. However, since Covid staff limited visitor contact where possible. For vulnerable patients, staff made efforts to facilitate carer or family support and identified key rooms so that these patients could have overnight support.

The service had enough suitable equipment to help them to safely care for patients. All three theatres and the recovery had all the equipment required for daily use. There was a large store which housed equipment that was not in daily use. Staff reviewed surgery lists to ensure that the correct surgical packs and prosthesis were available at the beginning of each shift.

Managers updated an asset log of all major equipment in the department. The location had a contract with an external company for servicing and repair of equipment. The company would issue reminders and attend site when maintenance checks were due.

Staff disposed of clinical waste safely. Staff received Control of Substances Hazardous to Health (COSHH) training, to make sure all staff handled and disposed of waste correctly. Leaders displayed wipe clean posters in theatres to remind staff how to handle hazardous substances. Procurement staff stored hazardous materials in locked cupboards and disposed of it in line with manufacturing guidelines.

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. Staff used the National Early Warning Score (NEWS) process and completed it during and after surgery in recovery. Staff used observation monitoring equipment to observe and record patients heart rate, respirations, blood pressure and temperature. Staff scored the results and escalated concerns to doctors if patients deteriorated.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used various patient risk assessment forms, these included a day case and endoscopy risk assessment form. This is because different procedures required different interventions. Detailed forms included patient's allergy status, medical history, admission observations.

Managers introduced a smart process for triaging patients in the pre assessment clinic. This model of pre assessment was a systematic approach to assessing patients and helped identify patients with extra needs or who cannot meet the inclusion criteria. This measure ensured that staff reviewed and completed referrals correctly and patients were in the right place for care and treatment.

Staff knew about and dealt with any specific risk issues. Staff used a venous thromboembolism (VTE) assessment tool during the patient's pre-admission check. After surgery, doctors reviewed and updated VTE scores to make sure patients received the correct advice or medication.

Staff used the Sepsis Six care bundle, which is a system to identify and monitor patients at risk of sepsis. Staff used a flow chart to ensure that they followed the process and liaised with doctors to review treatment and medication.

Good

Surgery

Theatre staff followed the World Health Organisations 'Safer Surgery' checklist before surgery commenced. Staff completed and filed the checklist in the patient's records. Theatre staff updated a white board to record staff attendance in each theatre, the number of patients in each theatre and their procedure details and other important information.

Anaesthetists recorded preoperative checks, these included the position of the patient, aids used to support positioning, the site of the tourniquet and temperature checks.

Theatre nurses known as 'scrub nurse' completed a 'operation episode' process and recorded details of the procedure which included times, swab, and needle counts. The nurse also recorded traceability surgery pack labels within the patient records.

Staff had access to a blood gas machine and universal blood was available in a locked fridge within the theatre environment. Blood was barcoded and the provider had a service level agreement with a neighbouring trust to provide extra supplies if required. Staff received training on how to store, retrieve and administer blood during emergency situations. Once staff completed training, they received a barcode to access the fridge when required.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). This service was available at the neighbouring NHS trust. Staff had the contact details; in the event of a concern staff would call the neighbouring NHS trust to ask for advice and escalate concerns.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff escalated concerns to the safeguarding lead who completed the appropriate referrals and arranged assessments. The clinical service managers shared outcomes with key staff involved in the assessment and used the information as training scenarios but excluded the patients details in line with the Data Protection Act 1998.

Staff shared key information to keep patients safe when handing over their care to others. As a result of an incident investigation leaders had implemented a robust handover mechanism called the "check and send" process. Staff checked patient details three times prior to surgery. Staff used a prepopulated handover checklist called SBARD which stood for situation background assessment recommendation and decision tool when handing over care. The tool was clear, well laid out and used when patients were transferred from theatres to the ward.

Shift changes and handovers included all necessary key information to keep patients safe. Staff attended daily handovers at the beginning of each shift. Managers made sure all staff working in theatres received the information required to keep patients safe. White boards outside theatres displayed which staff were responsible for which patient and patient records followed the patient from admission.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. Leaders reviewed staffing levels based on the needs of the service and adjusted levels accordingly. Managers encouraged flexible working so that staffing levels were safe. Managers made sure staff had the opportunity to increase their knowledge and skills by gaining exposure to other areas of the hospital. Staff did not raise concerns about staffing during the inspection.

Good

Surgery

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. Managers, reviewed rosters every day to make sure that shifts were covered by the correct team of staff, this ensured that there was always a safe competent skills mix. For example, a lead practitioner managed the shift, and each theatre was allocated surgeons and anaesthetist and operating department practitioners (OPD), theatre nurses, healthcare assistants and porters.

The ward manager could adjust staffing levels daily according to the needs of patients. Managers reviewed staffing each morning and escalated potential gaps to the clinical service manager. Rosters were available two weeks in advance so that managers allocated staff to the needs of the service.

The number of nurses and healthcare assistants matched the planned numbers. The service made sure that rosters matched the planned numbers. However, managers told us that staffing could be unpredictable at times due to the Covid pandemic and the rules regarding isolation.

The service had low and/or reducing vacancy rates. The service had recruited seven overseas nurses to cover staffing gaps. The service had three vacancies, these included a deputy clinical service manager, lead theatre practitioner and a registered nurse.

The service had low and/or reducing turnover rates. Records confirmed that the current vacancy rate was 12% in surgery.

The service had low and/or reducing sickness rates. Records provided by the service confirmed a hospital wide vacancy rate of 4.23%.

The service had moderate rates of bank and agency nurses. The service had managed to recruit from overseas, although records confirmed there were four vacancies. Also, the Covid pandemic meant that there were times when staff had to self-isolate. This meant that the service did use bank and agency.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The service had an 'in house' bank staff system. Each ward manager created a social media closed group for staff wishing to work overtime. This meant that staff were familiar with their teams and their environment.

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.

The service had enough medical staff to keep patients safe. The Medical Advisory Committee (MAC) are responsible for reviewing clinical governance, key performance, audit outcomes and the review of consultants practising privileges. They offered consultant grade surgeons and anaesthetists practising privileges so they could work at the hospital. Consultants worked part time for the service, they reviewed patients in outpatient clinics and attended planned theatre lists to complete surgical procedures.

The Executive Director had access to a pool of consultants that they could call onto to cover surgery most of the time. However, cover was not always available and an example of theatre list cancelled at the last minute, because it was too late to source an alternative consultant on the day.

Good

Surgery

The medical staff matched the planned number. Managers planned workload in advance and consultants had set days for their clinics and surgery. However, due to the Covid pandemic it was not always possible to match numbers. For example, on the day of our inspection one theatre list was cancelled because a doctor had developed Covid.

The service did not have a vacancy rate for medical staff. Mount Alvernia did not directly employ consultant anaesthetists or surgeons, because they work at the hospital under practising privileges, as such there is no vacancy rate.

Sickness rates for doctors was reducing. The service had experienced an increase in sickness due to the Covid pandemic. This was a national problem and managers had processes to update patients and postpone hospital attendances until staffing was safe.

Managers made sure doctors had a full induction to the service before they started work. New doctors were given an induction checklist to complete prior to commencing a shift. The information was sent to a third party organisation to ensure that all the necessary competencies were met.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The director of clinical services liaised with the contracted agency to make sure there was a RMO on site 24 hours a day seven days a week to advise and support teams. They made sure that the service had a flexible medical workforce with the right skills mix to deliver care to patients.

The service had a resident medical officer on site 24 hours a day who trained in advanced life support was available to support the team in the event of an overly sedated or collapsed patient. Also, consultant anaesthetist were on site during all general anaesthetic or sedation procedures. Key staff completed conscious sedation training.

Records

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

Patient notes were comprehensive, and all staff could access them easily. Staff used paper medical records to record patient care. The notes were comprehensive held details of patients risk assessments, surgery, and recovery care.

The service made sure that records followed the patient. When the NHS transferred patients for care, the service requested the NHS notes prior to the pre-assessment appointment. Once staff discharged patients, they returned patient records to the medical secretary for review and storage or and when applicable returned NHS notes to the relevant NHS trust.

Patients referred via the NHS had their diagnostic tests results transferred when applicable and staff could access fee paying patient results online via secure passwords on a need to know basis.

When patients transferred to a new team, there were no delays in staff accessing their records. Medical secretaries and admin staff made sure that records were available when needed, and staff made photocopies of records when patients required transfer to an NHS trust.

Records were stored securely. Staff stored paper records in locked cabinets in line with the Data Protection Act 1998, which is designed to protect personal data. The hospital had a medical records department which housed medical records in secure areas.

Good

Surgery

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 used corporate guidelines to support medicine processes. Staff received training on medication management and medicines calculation as part of their induction. Managers monitored compliance monthly, and staff completed annual medicines calculation sessions online.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. During the pre-assessment process staff recorded patients current medicines. Prior to surgery doctors reviewed medicines and adjusted doses when required. Prescription charts followed the patient journey and staff made sure that patients received their medicines on time and were given the correct advice regarding the effects of the medicine.

Staff completed medicines records accurately and kept them up-to-date. Prescription charts had prompts to ensure that staff completed them correctly. Staff updated prescription charts when they administered medicines to patients. Managers monitored documentation on an annual basis and fed back to staff any gaps identified.

Staff stored and managed all medicines and prescribing documents safely. Theatre recovery staff stored medicines in locked cupboards and each theatre had a stock of medicine which was locked away. Staff stored drugs controlled under the Misuse of Drugs Regulations (2001) in locked cupboards alongside the "controlled drugs log". Staff accessed this via keys and two people checked and signed for the required controlled drug.

On the wards staff stored medicines in locked clinical rooms. However, during our visit to the surgical ward, staff had left antibiotic medicine unattended and unlabelled in a locked clinical room. This posed a potential risk because it meant there was a chance the medicine could be interfered with as other staff had access to the area. When we approached staff for an explanation, they told us that this was because the antibiotic took some time to dissolve, and they had gone to assist another patient. We raised this with managers, who immediately reminded staff not to leave medicines unlabelled or unattended, even if it is in a locked room. After the inspection we spoke to the CQC medicine optimisation team who confirmed that the medicine does take some time to dissolve; and if it left for a moment, it must be labelled and locked away.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Staff gave clear accounts on how to administer medicine safely. There were signs on the cupboards to remind staff to carry out safety checks prior to administering medicines. Checks included patient details, allergies, type of medication, route of medication and amount of prescribed medicine.

Staff learned from safety alerts and incidents to improve practice. Staff reported medicine errors via the providers incident reporting system. Managers shared pharmacy alerts via the morning communication briefing. Managers were responsible for reviewing the errors, highlighting any gaps in learning, and implementing safer strategies when required.

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.

Good

Surgery

Staff knew what incidents to report and how to report them. Staff told us that when incidents occurred, they would report these to the manager, who would assist the staff member to record the incident on the service's digital incident reporting system. These meant that the quality of information was consistent and easy to review.

Staff raised concerns and reported incidents and near misses in line with provider policy. Staff knew how to access the risk and governance policy online to support the recording of incidents. The service had a healthy incident reporting culture where staff felt comfortable to report incidents and near misses.

The service reported one serious incident from January 2021 to January 2022. The quality and risk manager completed a rapid review with those staff involved in the incident. The quality and risk manager liaised with members of the Medical Advisory Committee and the director of clinical service to complete a route cause analysis. Leaders are required to send root cause analysis to their corporate team so that they can complete a second objective review to make sure lessons are learnt and shared with staff.

Staff reported serious incidents clearly and in line with providers policy. Managers in each department were allocated incidents to review. Staff investigated incidents in line with the providers serious incident policy. The quality and risk manager investigated incidents and a panel rated them by the level of harm that caused to the patient and the implications to long term health. Notifications were submitted to the CQC in line with Regulation 18: Notification of other incidents which is mandated in the Health and Social Care Act 2008.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff received duty of candour training and the service had a clear duty of candour policy. Staff recorded duty of candour conversation in the patient records and monitored these conversations via the investigation process. When things went wrong the hospital sent people written apology.

Staff received feedback from investigation of incidents, both internal and external to the service. Records confirmed that managers shared learning with staff via the daily bulletin newsletter, at handovers and when staff met for training days.

Staff met to discuss the feedback and look at improvements to patient care. The service had a robust process that made sure staff received feedback from incidents. Managers discussed any issues relating to care at the morning handover. Managers advised staff of updates to practice made as a result of an incident via the morning brief. Also, managers used staff training days as an opportunity to explore incidents and practice changes in greater detail to embed learning for all staff.

There was evidence that changes had been made because of feedback. Managers and staff gave us examples of changes implemented to practice because of feedback. For example, managers had updated the patient assessment records to included diagrams of the human body so that the area of surgery was documented on the diagram and checked before the procedure was commenced. The service introduced a three point checking systems, so that staff checked the forms three times prior to surgery, once on the ward, once by the person sent to pick up the patient and on arrival to theatres. Another example was missing equipment. Managers identified the need for two sets of arm rests for theatres and leaders purchased these because of the incident review process.

Managers debriefed and supported staff after any serious incident. Staff told us that when incidents occurred, managers would gather the team together to discuss what had occurred and debrief all staff involved.

Are Surgery effective?

Good

Surgery

Good

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Leaders worked alongside the corporate regional team to review and update policies. All policies contained a creation and review date, and clear references to current national guidelines. Managers disseminated update procedures via the weekly news which directed staff a link so that staff could sign to confirm they had read the update.

Managers discussed updates of National Institute of Care and Excellence (NICE) guidelines at the clinical governance committee meetings. Relevant and significant changes to guidelines were present at academic study days and team meetings.

Consultants completed a new procedural document request if they needed to introduce new practice that they had piloted in the neighbouring NHS trust. The consultant presented changes to practice at the Medical Advisory Committee, who referred the changes to the clinical and hospital governance meeting to implement the necessary changes to practice.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff followed the 'Mental Capacity and Deprivation of Liberty' standard operating procedure during patient reviews. For example, for essential surgery staff reviewed care plans and recommendations made by the referring hospital. Also, staff discussed care with their families or advocates so that decisions were made in their best interest. Staff recorded these conversations in the patient records.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers. Patient records included details of peoples psychological needs and discussed at handovers on a need to know basis for those staff providing care. Managers supported staff to care for patients with anxiety or depression and staff gave examples of how teams facilitated overnight stays for people with complex needs.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service adjusted 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. Staff supported patients with their dietary needs to ensure that they recovered quickly. Menus were varied and included vegetarian and halal options. Catering staff adapted menus to the needs of patients when required.

Good

Surgery

Patients waiting to have surgery were not left nil by mouth for long periods. In May 2021, the service conducted a fasting audit because research had identified a negative impact on post-operative hydration for patients. Staff encouraged patients to drink clear fluids up to two hours before surgery. The audit was ongoing to embed this practice for staff. As a result of the outcomes the service introduced the 'Think Drink, Sip and Send' strategy to make sure patients recovered well after surgery. The service shared early data with a neighbouring independent hospital.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Doctors prescribed intravenous fluids for unwell patients or patients who had long surgical procedures. Staff accessed fluid balance charts in the patients surgery assessment record. Staff recorded intravenous fluids and measured urine output via a catheter or measuring jug given to the patient when they visited the toilet.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff weighed patients during the pre-assessment appointment to check their body mass index to make sure they fit enough for routine surgical procedures. Staff completed a malnutrition universal screening tool (MUST) for long stay patients and reviewed the patients weight throughout their stay to make sure patients received enough nutrition to help them recover.

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. Staff used a pain scoring tool included in the patients surgical risk assessment record. Surgeons prescribed pain relief medication and administered the first dose during the surgical procedure. Staff monitored pain during the recovery process using a pain score template. Consultants reviewed patients with dementia and prescribed pain relief based on the patients current medication and in their best interest.

Patients received pain relief soon after requesting it. Staff used the patients medication chart to check the prescribed medication and provided pain relief as soon as possible.

Staff prescribed, administered, and recorded pain relief accurately. Doctors used the medication card to prescribed pain relief at the point of surgery and updated this if the patient needed any additional medication. Nurses made sure they recorded the administration of pain relief in accordance with the providers policy.

Patient outcomes

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

The service participated in relevant national clinical audits. National audits help the Department of Health to monitor the effectiveness of care. The service provided data for several national audits, these included the Patient Reported Outcome Measures (PROMS), the Breast Registry, the National Joint Registry and The Private Healthcare Network. Records confirmed audit compliance to be 100%.

The hospital submitted data to the Private Health Information Network (PHIN). PHIN is an independent non-profit organisation that publishes data to help patients make informed decision regarding their treatment options. PROMS data

for privately funded knee and hip replacement data for July 2020 to June 2021 confirmed a 47.85 response rate for hips replacements which was higher than the national average of 32.6%. 98.2% of patients stated their condition had improved because of surgery. The response rate was 42.3% for knee replacements with the national average of 31.6% and confirmed that 94.6% of patients reported improvements because of surgery.

The PHIN data also confirmed that there were no reported surgical site infections for hips or knees during the same reporting period. The service did not report any Healthcare associated infections in the same period.

Outcomes for patients were positive most of the time, consistent, and met expectations, such as national standards. The hospital completed audits for venous thromboembolism (VTE), National Early Warning Scores (NEWS), patient care, pain management and fasting. Audits included a checklist for staff to follow. Patient care was broken down into different segments, these included but not limited to consent, patient identification and clinical handovers. Outcomes for the audits were positive with most aspects scoring over 98%.

Managers and staff used the results to improve patients' outcomes. Leaders were keen to trial strategies that improved patient outcomes. For example, staff recently completed a patient warming “hotdog” trial in theatres. This was because research had found that patients who have had surgery are at greater risk of hypothermia (Peri-operative warming devices: performance and clinical application 2014). Controllers delivered a low voltage electricity to blankets and mattresses which is converted into safe heat via a patented conducive fabric. This trial is ongoing and early data identified that outcomes were positive.

The service had a lower than expected risk of readmission for elective care than the England average. Records confirmed that the readmission rate for Mount Alvernia surgery was 0.127 per 100 admissions.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service collected data on patient satisfaction and used the Patient-led Assessments of the Care Environment (PLACE) audit model and implemented an audit calendar so that numerous internal audits were completed throughout the year.

Managers used information from the audits to improve care and treatment. Managers reviewed outcomes of data to improve care for patients.

Managers shared and made sure staff understood information from the audits. Managers shared audit outcomes via the daily briefing and the monthly newsletters. Various audit data was displayed in the ward area, for example outcomes from the “sip and send” audit.

The service was accredited by the Joint Advisory Group (JAG) of Endoscopy in 2020. The accreditation process looked at several audits for surgery under the domains of safety, effectiveness and leadership and benchmarked parameters. JAG review the service on a yearly basis to make sure compliance is maintained.

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. The department consisted of healthcare professionals who specialised in different aspects of care. Consultant anaesthetists and surgeons

worked via the practising privileges scheme and the Medical Advisory Committee (MAC) and the registered manager monitored training compliance during annual practising privilege reviews. Nursing staff were employed on full and part time contracts. Key staff had specialised training, for example the anaesthetic nurse supported the anaesthetists with airways and observations.

Operating department practitioners (ODPs) were a part of the multidisciplinary theatre team, their role was to support patients during anaesthesia, surgery, and recovery, responding to patients' physical and psychological needs. ODPs were allocated to each theatres list.

A scrub practitioner was always present in theatres. They received specific training to assist surgeons during operations and made sure that the correct instruments were used, and swabs were counted after surgery.

All clinical staff completed intermediate life support training and 12 were trained in advanced life support (ALS). There was at least one ALS qualified member of staff on each shift.

Porters and healthcare assistants assisted with the daily running of theatres, by collecting patients, supporting clinical staff with collecting equipment, transferring patients and patient care in recovery. On the day of our inspection there were 23 staff on duty, and all had allocated responsibilities, worked methodically, and supported each other so that surgery lists ran safely.

Managers gave all new staff a full induction tailored to their role before they started work. The provider gave all new starters an induction booklet, the booklet contained information on governance, models of care, operating systems, and the circle philosophy. Seven new staff had been recruited from overseas and these staff had a 90 day induction program. This included a month of supernummery status, a process where new staff are not left alone until they feel confident in their environment. New staff told us their induction included competency assessments, and the clinical services manager liaised with a university to make sure staff received the support they needed to complete their skills tests.

Managers supported staff to develop through yearly, constructive appraisals of their work. The clinical services manager was responsible for completing appraisals and supported staff to identify their developmental needs, the appraisal rate for the ward was 90%. In theatres records confirmed the appraisal rate to be 94%.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. The clinical service manager offered clinical supervision to new staff, staff who were in the process of completing a course and staff who had been involved in incidents. This process was planned and documented in staff records. Records confirmed that the most recent meeting in January 2022 included a case review from a large NHS trust and group discussion by those present.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. The Medical Advisory Committee (MAC) reviewed the practising privileges of consultants annually. The reviewed General Medical Council (GMC) registration, mandatory training and made sure doctors submitted valid insurance on an annual basis.

The clinical educators supported the learning and development needs of staff and made sure staff received any specialist training for their role. Managers made sure that staff had time to complete their revalidation to the nursing and midwifery council (NMC) every three years and provided staff with opportunities to apply for additional courses. One example of this was ‘Pre-assessment training’ because pre-assessments of patients prior to surgery must be robust and identify any risks that may hinder routine surgery. Once staff completed the training, they were factored into the pre-assessment clinic roster.

Good

Surgery

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Since the COVID pandemic, managers had set up virtual staff meetings on an ad hoc basis and we did not see evidence of minutes to these meetings. However, staff accessed the daily briefing via emails and managers disseminated changes in practice via huddles, appraisals, and staff training days. Also, the service produced a staff newsletter, with topics of the month and outcomes of internal audits.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers used changes in national guidance, incidents, safeguarding and appraisals to identify gaps in learning.

Managers identified poor staff performance promptly and supported staff to improve. Managers told us that poor performance was rare within the service. This was because there was a healthy supportive culture. Manager would speak to staff members who appeared to be struggling to identify the issues that contributed to their poor performance.

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. All staff attended daily shift huddles to discuss theatres lists and patient care and treatment based on the pre assessment documentation. Topics discussed at each handover, included checking each patient had been allocated the correct surgical kit, moving and handling apparatus and any extra support that patients needed.

Hospital leaders participated in MDT meetings at four NHS trusts to strengthen working relationships and comply with their assurance processes.

Staff worked across health care disciplines and with other agencies when required to care for patients. Leaders negotiated service level agreements with the neighbouring NHS trusts which meant they had easy access to key NHS services to discuss the needs of patients prior to and after surgery. Administrators filed copies of MDT outcomes letters in the patient record.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. The service did not provide an “in house” psychiatric assessment. Although, key staff had training to identify patients who showed signs of mental ill health and depression. The lead nurse gave examples of how they had supported staff to refer patients to the mental health services and fed back outcomes to staff as a key learning opportunity.

Seven-day services

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

Consultants led daily ward rounds on all wards, Monday to Friday, and were available remotely over the weekend. Consultants reviewed patients after surgery and throughout their stay. Consultants visited their own patients at least once a day during the post-operative period and completed and updated the patient risk assessment. When consultants were unable to attend their own patients nursing staff contacted the resident medical officer (RMO). The clinical teams contacted consultants when they were off site if they had a query about patient care.

Good

Surgery

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. The service has a 24 hour diagnostic testing department covered by an on call rota out of hours. Managers had local agreements with neighbouring NHS trusts so they could access their services. For example, clinical service managers could seek mental health advice and arrange additional appointments or transfer unwell patients to local NHS teams.

Health promotion

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

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Prior to surgery patients were sent information leaflets relevant to their procedure. The service had relevant information promoting healthy lifestyles and support on wards. Staff provided leaflets on hydration, dietary information, wound care, post-operative care and physiotherapy.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff followed the Consent for Assessment, Care and Treatment and the Mental Capacity, Deprivation of Liberty and Restrictive Practice policies, which included a list of roles and responsibilities; to support the process of consent for treatment or examination. Both policies were in date and had scheduled review dates.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Consultants followed the hospitals policies and completed consent documentation during assessments with the patient. Managers monitored compliance every four months and records confirmed 100% compliance; consent was recorded, legible and signed for.

Staff made sure patients consented to treatment based on all the information available. Staff received additional training to enable them to pre assess patients prior to surgery, within this process staff gave patients all the information they needed to make informed decisions. Patients signed consent forms and stored these within the patient record.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff told us they followed the providers mental capacity and Deprivation of Liberty policies which included the process to make decisions for the best interests of patients. Because the service supported the NHS during the Covid pandemic staff had seen an increase in caring for patients with dementia. Staff gave families and carers dementia passports to complete, to help staff understand the needs of dementia patients.

Nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS). Staff training included identifying people who may lack capacity to make informed decisions. Staff gave examples of how they recorded and escalated concerns via the patient service manager when patients appeared to be confused or suffering from delirium.

Good

Surgery

Medical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Consultants received this training as part of their NHS role the Medical Advisory Committee (MAC) monitored compliance. The hospitals risk register confirmed that there was an associated risk with managing compliance because consultants had busy theatre lists and dual roles. Records confirmed this risk was being monitored.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Deprivation of liberty safeguards recently changed to Liberty Protection Safeguards and are an aspect of the Mental Capacity Act (2005). Staff used the legislation to make decisions about patients who lacked the capacity to safely care for themselves in a care setting. The director of clinical services supported the clinical quality and risk manager to monitor staff compliance to using the legislation for patients who made need to be restrained to protect themselves. For example, a dementia patient at risk of wandering from the ward.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff accessed policies via the hospitals staff portal, they told patient services managers about concerns and completed incident forms and safeguarding if and when required. Also, there was a nurse specialist who was trained in dementia care on each ward who had received extra training to support staff and given accurate advice.

Are Surgery caring?

Good

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

Compassionate care

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

Staff 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. Since the COVID pandemic, staff had seen an increase in patient anxiety, because of this staff took more time to speak to patients about their fears. Patients told us staff were respectful and the last quarter patient survey confirmed this.

Patients said staff treated them well and with kindness. Staff took time to care for patients, patient feedback comments included, “people were so kind and understanding and that my worries disappeared”.

Staff followed policy to keep patient care and treatment confidential. In theatres staff worked quietly and drew the curtains when discussing patient care. On the wards handovers were discreet and staff spoke to patients in their room to ensure confidentiality.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff recognised the sunflower lanyard scheme used to identify people with disabilities and made sure these patients had their needs met during their stay.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. The hospital had a chapel and quiet rooms for reflection and prayer. The hospital was operated and managed

by the Franciscan Missionary of the Divine Motherhood up until 2005. It was a calm environment and was being updated to be more inclusive of the needs of people from different religions and cultures. For example, the hospital had purchased a Muslim prayer mat for patients or staff who needed to use the space, and the director of clinical services was planning a cultural engagement piece, to identify any gaps in cultural and religious needs.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. The hospital had a visitor by exception scheme for people with extra psychological or dementia needs. The clinical services manager completed risk assessments and planned care to make sure patients had the support of a carer or family member during their stay, the risk assessment included a COVID lateral flow test to limit the risk of cross infection

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. The theatres recovery area had five beds which provided adequate space and curtains around each bed to make sure privacy and dignity were maintained. Patients on the wards had their own rooms.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Key staff had training in breaking bad news and followed the hospitals operating procedure. Carers were risk assessed so they could attend meetings with patients in the event of bad news. The hospital had designated quiet spaces for those who were anxious to use.

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. Patient feedback was positive, for example one comment was "you were and are brilliant at what you do, lovely people who know the true meaning of the vocation you have chosen, nothing was too much trouble for you".

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. The hospital highlighted communication issues via the patients referral and pre assessment. Staff liaised with families to make sure they supported peoples communication needs. Key staff had training on how to communicate with people who had learning difficulties.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff gave patient feedback cards to people at the start of their care. Staff collected these during the discharge process. Patient satisfaction survey reports were published every month. Managers made sure that outcomes displayed in clinical areas and on the hospitals internet page.

Staff supported patients to make informed decisions about their care. Staff used patient information leaflets and other resource to help patients make informed decisions. The patient satisfaction results for December 21 confirmed that 100% of patients were supported in the decision making around their care.

Good

Surgery

Patients gave positive feedback about the service. December 2021 report looked at 508 responses, outcomes were good. Records confirmed that 100% of patients felt they were involved in decisions regarding their care, 100% felt there was privacy when discussing their care and 97.7% of people said they were kept informed of the expected discharge date.

Are Surgery responsive?

Good

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

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population. The hospital supported three local NHS trusts via service level agreements to reduce elective surgery waiting lists for orthopaedic, gynaecology, maxillo-facial and trauma NHS patients.

Facilities and premises were appropriate for the services being delivered. The hospital was undergoing redecoration, the premises was spacious, the theatres were on the top floor and staff accessed these via lifts. They were light airy and spacious. On the ward all patients had their own rooms with toilets and showers. Staff had their own comfort room, offices, and clinical rooms.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. The hospital linked with the neighbouring NHS mental health services if they needed it. Also, staff had links with GP's and community services. However, there was no onsite emergency mental health assessment.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff assessed people's needs and made sure that support was there when needed for example, staff invited carers to the hospital to assess the environment to make sure it was adequate for the patient.

Managers ensured that patients who did not attend appointments were contacted. Staff contacted patients who did not attend twice. Managers referred NHS patients back to the NHS if they did not respond after a telephone call and a letter. On average bookings were made within 16 days of a cancellation.

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 hospital had systems to support patients with mental health, learning disabilities and dementia. Staff highlighted patients' needs during the referral and pre-assessment process. Dementia leads were available on the wards and 20 staff had completed "dementia friend" training and leaders had made environmental adaptations to the ward. This meant that there was round the clock support for people who had dementia.

Good

Surgery

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff completed dementia passports throughout their surgical journey when required, and families supported staff to do this. The information was kept with the patient to help make sure care was consistent and based on the patients needs.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The hospital purchased different colour cutlery, trays, and plates to help dementia patients identify their food and remind staff that the patient had complex needs. Also, the signs on toilets were "dementia" friendly.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The hospitals referral form prompted referring services to highlight the interpreting or signing needs of patients so that staff could pre-arrange these services. Staff had access to dementia aids, British sign language and telephone interpreting services when they needed them. Posters were displayed in line with the providers accessible information policy.

The hospital supplied information leaflets in different languages and sent them pre-operatively when required. Staff had contracts with services that provided support for people who were visually impaired or deaf.

Patients were given a choice of food and drink to meet their cultural and religious preferences. The catering services adapted to the needs of the patients. Patients were given a daily menu at the start of each day. Staff contacted the catering team when patients required adjustments to the dietary needs based on their religious preferences, who made sure they gave patients a choice.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Consultants completed assessments of their waiting lists and submitted triage forms stating the priority of the patient, this included an assessment and supporting evidence.

Managers monitored activity to make sure the service had adequate facilities and staffing. The service admitted a total of 7,400 patients and 1,370 of these were for NHS patients. There were 411 gynaecological procedures and 1371 orthopaedic procedures from the February 2021 to January 2022.

Managers and staff worked to make sure patients did not stay longer than they needed to. Consultants worked closely with nursing staff to make sure patients recovered well from surgery. Managers and staff worked to make sure that they started discharge planning as early as possible. Staff organised discharges in advance they reviewed patient observations, liaised with doctors, GP's and other third party organisations to arrange care packages when required and updated records in a timely manner.

The hospital reported varied referral to treatment times from April 2021 to January 2022. On average 87% of general surgical patients were seen within the 18 week target of 92% set nationally. Gynaecology patients were on average seen within the target 84% from April 2021 to January 2022. Twelve other specialities including ophthalmology, dermatology and cardiology referrals were treated within 18 weeks 100% of the time.

Good

Surgery

The service reported some treatment delay had been related to patient choice and wishing to postpone surgery during the pandemic. Mount Alvernia supported the NHS through two COVID-19 which had led to longer waiting times in some cases. At this time the hospital were prioritising NHS patients alongside and also had reduced consultant availability.

Managers worked to keep the number of cancelled appointments/treatments/operations to a minimum. Staff gave patient dates for surgery and additional information about the admission process. Administrative staff called patients 24 hours prior to surgery to make sure people had completed COVID testing and would be attending their surgery. However, data from January 2021 to Jan 2022 confirmed there were 1045 amended, postponed or cancelled operations, which included those that were cancelled or re-arranged by patients. Managers monitored the reasons for cancelled procedures which included 368 patients who cancelled their procedure for personal reasons and 286 cancellations on the request of the consultant.

When patients had their appointments or operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. On the day of our inspection, the hospital had to cancel one theatre list due to a consultant surgeon testing positive for COVID. Staff called those patients involved and re-arranged their procedures as soon as possible. Managers collected data on cancellations and created action plans when necessary.

Staff did not move patients between wards at night. This was because patients were admitted during the day and allocated their own room

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Staff liaised with GP's and community services when patients had complex needs. If a patient had a safeguarding referral the director of clinical services made sure staff implemented care packages prior to discharge.

Staff supported patients when they were referred or transferred between services. The hospital had a robust inclusion criteria to make sure patients treated safely on site. The pre-assessment process identified patients referred where it would be clinically inappropriate for their care to be at the hospital. This meant that it was rare for patients to be referred to other services. Although, some NHS patients had to be referred to the NHS for unsuitability to elective services at Mount Alvernia. Staff made sure that patients who needed transfer to an NHS trust for further treatment were well informed and staff updated families, and all belongings were checked and transferred with the patient.

In the event of an emergency transfer to an NHS emergency care unit. Clinical service managers communication with the receiving NHS unit, arranged an ambulance and deployed key staff to stabilise the patient until the ambulance arrived to collect the patients.

Managers monitored patient transfers and followed national standards. Staff recorded patient transfers on the internal incident reporting systems. Managers monitored and reviewed the care records of those patients who required transfer to make sure the appropriate care was given in a timely manner.

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

Surgery

Patients, relatives, and carers knew how to complain or raise concerns. Staff gave patients patient satisfaction cards at the start of their care and treatment. The cards contained information on how to feedback, raise concerns and make a complaint.

The service clearly displayed information about how to raise a concern in patient areas. The hospital displayed information on how to make a complaint in patient information leaflets, on boards throughout the hospital and on their website.

Staff understood the policy on complaints and knew how to handle them. The service had a clear policy for handling complaints. Managers recorded complaints on the internal incident reporting system. Staff escalated complaints to managers who reviewed the patients and supported them to complete the complaints process.

Managers investigated complaints and identified themes. The quality and risk manager met with managers and clinical service leads to discuss complaints. During the last year the hospital had received 44 complaints. Managers completed quarterly audits against the compliance of the complaints process.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The clinical services managers acknowledge complaints within three working days. The managers gave patients feedback and when things went wrong offered a written apology.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers documented lessons learned and sharing learning via daily communications, newsletters, and team study days.

Are Surgery well-led?

Good

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

Leadership

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

The executive director led services at the hospital, had overall responsibility for the hospital and was the registered manager. The director of clinical services, and the clinical chairperson managed services and fed back to the executive team. The Circle Health Group Limited Senior Management Team (SMT) were available to always support the local team. The team consisted of regional leads and national experts who could offer advice and support.

The director of clinical services managed the heads of departments, including the theatre and the ward managers, and the pre-operative lead.

The executive director and director of clinical services were known to all staff and seen regularly on the wards. Both had a clear understanding of the issues within the hospital and shared plans to manage the service with staff on a regular basis.

Good

Surgery

The senior management team supported staff to develop their skills. Managers encouraged career progression for staff through regular one to ones and appraisals and where appropriate offered apprenticeships, and recognised qualifications, which were funded by Circle Health Group Limited.

The hospital interim clinical services manager in theatres had been covering the post since December 2021. The hospital had appointed a new permanent manager to fill the post who was due to start within the month.

Line managers fed back any corporate communication at team meetings. Circle Health Group Limited senior management team came to the hospital regularly to speak with staff and answered any questions they had.

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.

Circle Health Group Limited had recently introduced a new vision, known as 'The Circle philosophy' which was shared with staff and displayed on the hospitals internal digital systems. The purpose was "to provide high quality, safe and compassionate care our patients need and expect". The hospital had four key principles patients, people, open minded and innovative. These were underpinned by eight values selfless, compassionate, collaborative, committed, agile, brave tenacious and creative.

The local objectives linked with the corporate objectives but were relevant to the Mount Alvernia Hospital. Heads of department discussed surgery objectives during their team meetings and these conversations formed the personal objectives for staff appraisals. Appraisals objectives were aligned with the core values and managers encouraged staff to set these at appraisal meetings with time frames for completion.

Corporate emails were set alongside values and behaviours. The staff induction process included an overview on the providers core values to help embed them into daily working life.

Key staff attended daily hospital wide meetings and followed a set agenda and followed the key principles set out by Circle Health Group Limited.

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 reported that the leadership culture was inclusive, and they felt valued and respected. Relationships between staff at the hospital were positive, with strong teamwork and collaboration. There was a strong emphasis on the safety and well-being of staff; for example, in the daily huddle there was an agenda item which included staff recognition called 'shout out's' for staff who made exceptional efforts to provide holistic care.

Circle operating champions were available for staff across the hospital. They played a major role in modelling the Circle Health Group behaviours and supported colleagues to embrace all operating systems into their working day.

Good

Surgery

Managers made sure they shared positive feedback with staff as soon as the feedback had been received via the hospital. Staff could nominate each other for 'Oscars', the values recognition scheme. There were awards for staff going above and beyond. Recently the hospital parking attended received this award following consistent positive feedback from staff and patients.

Staff told us they could raise concerns with anyone in the hospital and felt there was no hierarchy or blame applied when things went wrong. There was a culture of acting in accordance with the duty of candour. Leadership and staff showed an understanding of their responsibilities and a willingness to acknowledge shortcomings.

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 Circle Health Group Limited recently launched a new governance assurance framework. The hospital had a clear governance structure. Leaders used the governance and assurance framework to develop and inform local governance strategy and policy.

The hospital management team reported to a regional team via the clinical governance committee. The committee was responsible for health and safety, medicines management and infection prevention control. The regional team reported to the national executive.

The Medical Advisory Committee (MAC) was responsible for advising on practicing privileges, particularly relating to the scope of practice. The MACs reviewed all clinical governance issues such as all clinical complaints, deaths, and adverse events. They worked closely with the hospital director and met four times a year.

Several committees fed into the quarterly MAC and quality and safety meetings. This included infection prevention and workforce committee, clinical governance committee and medical governance committee. Meetings were well attended and included discussions around risks, learning from incidents, complaints, and endorsements.

Leaders made sure that regular governance meetings took place so that accurate information was discussed and shared with key staff. There was a comprehensive daily and weekly communication strategy this included compliance with national guidance such as NICE and safety alerts.

There was an interactive guide on the Mount Alvernia Hospital intranet which set out terms of reference and attendance.

The hospitals director reviewed consultants with practicing privileges every two years. Consultants were also subject to annual practice reviews through the MAC. The executive director held a monthly medical governance meeting at the local NHS to discuss performance and any concerns.

The Circle group introduced 'Patient Hour' which referred to any period dedicated to exploring patient feedback and experiences as a team. During patient hour managers questioned whether staff had provided the best care possible and if they gained or retained the trust and loyalty of their patients. Improvements to practice were made if issues were highlighted during this process.

Good

Surgery

Management of risk, issues and performance

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

The Circle Operating Systems was at the heart of managing risk, issues and performance. The model included safety strategies to help reduce risk, whilst maintaining performance. Managers used strategies to limit risks within the service.

The "Stop the line" initiative encouraged staff to stop a procedure and report to the manager if they had identified an immediate risk. This process activated the 'Swarm' approach which is a safety incident huddle to rapidly solve problems. It is called Swarm because staff rapidly attend the site of the incident. This practice enabled staff to make quick informed decisions as a collective to improve patient care.

Staff identified risks and used the incident reporting tool to upload them to. Leaders reviewed and updated incidents on a weekly basis, to make sure that incidents were reviewed quickly, and any learning shared with the wider team.

Managers added risks to service delivery to the risk register appropriately and gave a risk score depending on severity. There were departmental risk registers and a hospital wide risk register, which fed into the regional and corporate risk register. The top risk was risk of fire spreading to other fire compartments due to a breach in fire dampers and service risers. However, the provider had taken steps to mitigate the potential risks. We also saw evidence that financial contingencies had been allocated to address the issues and works were due to commence in the next month.

The second risk was the potential lack of oversight for consultants' practising privileges. This was highlighted as a risk because workload and capacity meant that biennial reviews, appraisals, and indemnity may not be in place. Leaders reduced this risk because the Medical Advisory Committee and registered manager monitored this on a weekly basis and we saw an example of this during our inspection when a consultant was asked to provide evidence of their indemnity insurance before they could embark on a surgical list.

The executive director and director of clinical services reviewed this regularly. This included reviewing the risk, removing mitigated risks, and updating any actions. Managers escalated risk corporately to Circle Health Group Limited as appropriate.

Managers encouraged staff to report risk as soon as a risk was identified by implementing a safer model of escalation. Staff used the 'don't wait escalate' model to escalate practice concerns. Leaders had an open door policy to report any concerns. Managers told us supported staff to complete incident reports to make sure practice was embedded.

In surgery there were four incidents that were over 60 days, this was because the incidents are reviewed at local level by the risk and governance team and then they are sent for a peer review to the regional office.

Leaders considered the impact on sustainability, efficiency and quality when developing services. The service reported no instances where financial pressures had compromised care.

The service had business continuity plans, which included major incident plans.

Good

Surgery

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.

Parameters had been set in agreement with local and national thresholds, which allowed the service to benchmark themselves against other independent hospital and NHS acute trusts. The service submitted data to external bodies as required, such as the Patient Reported Outcome Measures (PROMS) and the National Joint Register. This enabled the service to benchmark performance against other providers and national outcomes.

The service had not reported any data breaches and systems were secure. Patient identifiable information was handled correctly, and patient names were not visible from the ward areas to ensure privacy.

The hospital had recently started an accessible information standard working group which aimed to ensure access information was accessible to all.

Engagement

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

The hospital supported a local charity which offered respite care for children and young adults with a range of complex disabilities.

The Hospital held “giving something back” meetings with representation from departments across the hospital and charity staff to see where support can be offered across the service.

Staff had regular opportunities to meet with and engage with the senior management team.

There were several examples of cross organisational working with the aim of improving services for both staff and patients. For example, a new quality improvement idea was shared with another the independent hospital, this was the “Think Drink Sip and Send” campaign previously discussed in this report.

The hospital was built on a historic convent and contained religious artefacts from that period. Staff had access to a chapel and private prayer room. Managers were working towards greater culturally inclusivity. Staff had access to a chaplaincy and leaders funded an Islamic prayer mat so that Muslim staff or patients could attend their prayers and use the chapel. Leaders had engaged with staff and patients to make sure all spiritual needs were met, so everyone using the service had access to a spiritual space that made them feel comfortable and welcomed.

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.

Leaders were committed to improving services through a process of education supported by up to date evidence and new technologies. Quality improvement methods underpinned this process and the corporate team reviewed and ratified any new practice to ensure good governance and safety.

Good

Surgery

The surgical leadership team gave us several examples of improvements to practice implemented during the reporting process January 2021 to February 2022. For example, the implementation 'Don't Wait Escalate' which was a simple guide staff used to escalate concerns to managers. The system used a traffic light system of Green for not urgent to Red which was a serious concern and staff made immediate escalation to a manager.

Also, the 'Think Drink, Sip and Send' initiative. Leaders implemented this to increase recovery rates for patients after surgical procedures. Research had shown that patients who were well hydrated recovered well and could be offered sips of water up to the point they left the ward for surgery.

Leaders implemented the 'Comm Cell' daily update model to make sure staff had daily robust updates about all aspects of surgical activity. The 'Comm Cell' was a questionnaire that managers completed at the beginning of each shift. The information included, a general update, what was happening across the hospital, safeguarding, alerts, staffing throughout, the names of key 'on Call' people and onsite training.

The corporate governance team introduced the Accessible Information Standard (AIS) to make sure people with a disability or sensory loss were given assistance and information in formats they could understand. Staff followed a clear process, which began with "Ask", at the first point of access patients were asked if they had any communication or impairment needs. Staff recorded this information in the patients records and updated the 'Comm Cell' sheet, the information shared on a need to know basis. Staff made sure that patients were signposted to key staff like patients champions.

Good

Diagnostic imaging

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

Are Diagnostic imaging safe?

Good

Our rating of safe improved. 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. Records showed 100% of staff had completed their mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff.

Managers checked mandatory training and alerted staff when they needed to update this. Managers showed suitable oversight of the mandatory training using a training matrix that showed the mandatory training status for each staff member and the status of each individual module.

Managers sent email reminders for staff to complete mandatory training. The manager followed up and supported staff who had not completed training on time.

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. Staff were all trained to level two or three in adults and children, depending on their level of clinical responsibility. There was a safeguarding lead for the department to report concerns to.

Staff knew how to identify patients at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff could access contact details of nominated local safeguarding individual if there were urgent concerns.

Good

Diagnostic imaging

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There had been no safeguarding incidents in the last six months, but staff showed a good knowledge of what actions they would take if they had concerns.

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.

Managers monitored clinical areas and furnishings were clean, suitable and well-maintained. Staff ensured cleaning records were up-to-date and showed that all areas were cleaned regularly. Managers reviewed cleaning records for the department.

Staff followed infection control principles including the use of personal protective equipment (PPE). Personal protective equipment was readily available, and staff followed guidelines around the safe removal of PPE, this included the extra requirements for staff working in IR(ME)R environments.

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 service followed national guidance. The department had a molecular imaging department that conducted nuclear medicine and PET-CT. Additionally, MRI/CT, X-Ray, and ultrasound scanning equipment was available in the department.

The molecular imaging department conducted specialised services that required IR(ME)R requirements associated with the environment and equipment to be met. Three clinical rooms were nominated for molecular imaging and suitable processes ensured that separate facilities were made available for patients including toilets and separate emergency equipment. There were suitable arrangements to restrict access to the molecular imaging area for staff and patients. Suitable warning signage was seen in the department. A medical physics expert (MPE) was available to staff working in the unit and we saw good team working between them on the day of our visit.

The department had the correct permits associated with IR(ME)R clinical waste disposal and we saw waste monitoring checks associated with this.

However, it was seen in some treatment rooms that the wheel brakes on chairs were in need of repair. The chairs had been moved to areas of the room where they were stable, but this provided difficulties in staff being able to monitor patients fully as they were seated away from monitoring cameras. Managers said that the chairs were due for replacement and that it was on an action log for the department but there was not a time frame associated with this yet. We confirmed this arrangement through meeting minutes that clearly identified managers had awareness of this but that no timeframe had been given for actioning this.

The MRI/CT suites had restricted entrances and displayed large warning signage on the floor and doors. There was a private changing room area for patients.

Staff carried out daily safety checks of specialist equipment. All equipment within the MRI/CT suite was correctly labelled MR “safe” or MR “conditional” in line with The Medicines and Healthcare Products Regulatory Agency (MHRA) recommendations.

Good

Diagnostic imaging

The MRI/CT machines had a service level agreement for maintenance. There was a process for reporting faults and maintenance was scheduled so that patient care was not disrupted.

The department had a health and safety audit conducted between October 2021 and January 2022, the department met the expected standard set by the hospital.

Staff carried out daily safety checks of specialist equipment. Staff checked resuscitation equipment daily and managers checked records for completion. Records of when this equipment was last serviced with a date for review were accessible electronically.

The department had enough suitable equipment to help them to safely care for patients. Stock was kept in secure locations and all stock checked was in date.

Staff disposed of clinical waste safely. Sharps bins were correctly labelled and not overfilled. Waste was separated and kept securely until collection. The collection and safe disposal of sharp bins and clinical waste was aligned to the hospital processes.

There were risk assessments and reviews of the materials subject to control of substances hazardous to health (COSHH) regulations.

Assessing and responding to patient risk

At our previous inspection, we had concerns over the assessment and response to risk in the department. The department had taken some action to partially mitigate the risks.

Staff completed safety questionnaires with patients prior to their scan at the department. Staff reviewed pre scanning information from the referrer prior to seeing a patient. However, we reviewed a sample of these forms and found that some safety sections to be filled out by the referring clinician were incomplete. Despite this, when forms arrived that were incomplete, the staff sought the information directly from the patient.

We asked the department manager about their current approach to these forms and they were transparent in their current approach to checking the forms. Managers showed examples where incomplete pre-assessment forms had led to learning events which were shared with the department team during meetings. This showed a culture of learning and minimizing of risks to patients. Staff responded promptly to any sudden deterioration in a patient's health. Pathways were clear for deteriorating patients. Staff were able to explain the actions they would take to safely manage a sudden deterioration of a patient.

Staff completed standard risk assessments for patients on arrival. Staff knew about and dealt with any specific risk issues. Safety questions were asked before scans which included questions around any metal objects that the patient may have, for example, pacemakers or metal pins in the body. This formed a separate process to the pre assessment referral form.

Staff had access to 'The Identification and Management of Contrast Drug Reaction and Extravasation Guideline' dated July 2020. It outlined the signs and symptoms of mild, moderate, and severe signs of adverse reactions to contrast agents and other medications. An anaphylaxis kit was available in the department and staff were trained in how to use it when this was required.

Good

Diagnostic imaging

The service followed local rules associated with ionising radiation regulations 2017 (IRR17), and employers' procedures, ionising radiation (medical exposure) regulations [IR(ME)R. These regulations deal with the safe and effective use of ionising radiation; they were up to date, signed and displayed.

Staff knew about and dealt with any specific risk issues. For example, staff asked eligible patients about the possibility of pregnancy before scanning them following IR(ME)R guidelines.

Illuminated signs showed when radiation was active in ionising radiation areas to warn people not to enter. The department was supported by a Radiation Protection Advisor (RPA). A Radiation Protection Advisor is an individual, or corporate body, that meets the Health and Safety Executive criteria of competence and has the necessary experience and expertise to advise on the organisation's use of ionising radiation.

A radiation protection supervisor (RPS) was available to provide any extra advice staff may need. Managers appoint an RPS for the purpose of ensuring compliance with IRR17 for work carried out in an area which is subject to Local Rules.

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. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough staff to keep patients safe. The department had sixteen members of staff listed for the department. This included one clinical services manager who had oversight for ten radiographers. Other professionals included technicians and assistant radiographers.

The manager could adjust staffing levels daily according to the needs of patients. Staffing was increased in-line with demand. For example, patients were seen in the late afternoon because only two radiographers were available at the time. Managers made a conscious choice to maintain a service but to consider the risks of a lower number of qualified staff by restricting which scans should be booked during this time period.

Managers made sure all bank and agency staff had a full induction and understood the service. The department had arrangements for agency or bank staff and completed an induction checklist relevant to the location. Two bank radiologists were available for the department.

Records

Staff kept detailed records of patients' care and diagnostic procedures. Records were clear, up-to-date, stored securely and easily available to all staff providing care. Staff always had access to up-to-date, accurate and comprehensive information on patients' care and procedures. All staff had access to an electronic records system that they could all update.

Patient imaging records were complete, and all staff could access any historical images easily in the electronic system prior to undertaking the requested procedure.

Radiographers recorded checks followed procedures, that included recording the name of the operators who carried out the procedure, confirmation of the imaging performed, and associated radiation dose. Radiologists were able to access images once the scan processing had been completed to assess clinical findings and produce a report.

Good

Diagnostic imaging

Records were stored securely in a computer system that followed information governance processes of the hospital. Computer access was password protected and display units shielded from public view. Computers were locked when not in use.

Medicines

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

Staff followed systems and processes to safely administer, record and store medicines. Pharmacy staff stored medicines in a suitable manner and restricted access to them. Pharmacy staff checked contrast stock levels and managed stock rotation. We checked a sample of contrast medication and found all items to be in date. However, we did not see any written records in the department that verified this was taking place. Managers expressed that these records were held in the pharmacy department, but our team were unable to verify this.

Incidents

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

Staff knew what incidents to report and how to report them. Staff could report incidents and near misses to an incident reporting system. Staff understood and demonstrated through examples incidents that had been reported in the department. The department reported 30 incidents between November 2021 and January 2022. The largest number in one month was 13.

Managers of the department shared learning with the team about incidents that happened in other departments through the daily communications call.

Staff reported incidents under IR(ME)R appropriately and investigations were carried out by staff trained to do so. We saw example documentation following a near miss incident in the MRI/CT scanning room. The incident had been discussed with the team using their own learning framework to identify lessons that could be carried forward.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. Managers supported staff after any serious incident and held debriefing sessions.

Staff received feedback following incident investigations, both internal and external to the service.

Are Diagnostic imaging effective?

Inspected but not rated

We currently do not rate effective for this core service.

Evidence-based care and treatment

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

Good

Diagnostic imaging

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The department had policies available electronically to support good practice. Changes in national guidance were communicated to leaders from senior managers and the medical governance groups and implemented at the department level. Managers of the department held oversight of this information and distributed suitable updates during department meetings. We saw examples templates and policies in relation to this post inspection.

Wider information is available in our surgery core report.

Nutrition and hydration

Staff took into account patients individual needs where food or drink were necessary for the procedure.

Patients would be assessed prior to their scan for their nutritional needs. A drinking water machine was available for patients.

Pain relief

Staff assessed and monitored patients to see if they were in pain.

Patients were assessed for pain relief prior to a scan if this was indicated in their pre scan paperwork. Staff would assess the suitability of a scan and the adjustments that should be made for patients to be comfortable during their scans at both the triage and pre scanning stage of treatment.

Patient outcomes

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

Managers undertook internal weekly audits that were monitored at hospital level but did not participate in any national clinical audits. Managers and staff carried out a programme of repeated local audits to check improvement over time. This included requirements associated with IR(ME)R guidance. We looked at an annual report from the radiation protection advisor that covered radiation safety that was completed in April 2021. We also reviewed an MRI/CT physics report from January 2021. The audits ensured standards of safety were met consistently.

Further detail on audits at provider level can be found in our Surgery core report.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

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. All new staff working in the department were given an induction pack which gave details of systems in the department and a wide range of other information. These packs contained sign off sheets for staff to become competent in the relevant areas of their role, and staff were also allocated a mentor for support.

Managers supported staff to develop through yearly, constructive appraisals of their work; staff felt appraisals were supportive and helped them in their development.

Good

Diagnostic imaging

Managers explained that each member of staff had training profiles reflecting their mandatory training requirements.

Managers made sure staff received any specialist training for their role. For example, training from manufacturers on new equipment and updated software.

Multidisciplinary working

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

Staff worked across health care disciplines and with other agencies to care for patients. The service had worked collaboratively with the local NHS acute trust to share care and treatment of patients especially in oncology. For example, Managers reserved Thursday mornings for patients lists from the local NHS acute trust.

Diagnostic test results were available to support prompt MDT decisions on cancer care, treatment plans and support achieving cancer waiting time standards.

Further details at provider level can be found in our Surgery core report.

Seven-day services

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

The department was available Monday to Friday between 8.30am and 7.00pm and Saturday between 9.30am and 12.30pm with a radiographer on-call service outside of those hours.

Health promotion

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

Staff and patients could access relevant information promoting healthy lifestyles and support. There was information available about the variety of imaging scans and what would happen during them. This included what preparation was required prior to a scan and self-care advice following a scan.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care. They followed national guidance to gain patients' consent.

Staff at the department all completed mandatory training for consent. Staff gained consent for each scan undertaken and we saw this process during our visit. Evidence of correctly completed consent forms and staff verifying consent was seen during the inspection.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act (MCA) 2005. Staff could describe and knew how to access the policy on the MCA 2005.. Staff received and kept up to date with training in the MCA (2005) and understood the considerations needed with patients. Staff would verbally check with patients to ensure they understood what was happening and why they were having their scan.

Staff did not have examples associated with complex consent but a policy was available which took into account the requirements of the MCA (2005).

Good

Diagnostic imaging

Are Diagnostic imaging caring?

Good

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

Compassionate care

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and procedures.

Patients gave positive feedback about the service. Comments Included:

"Great Service, good explanation of all the procedures"

"Through, clear, professional"

"Excellent Care, very attentive staff"

Senior managers provided us with results and analysis from the postcard scheme run at the hospital. Between December 2020 and December 2021, positive feedback accounted for 99% of responses. Senior managers produced a monthly report that divided the data up in two ways, this was the funding type and the service that the respondent saw during their visit.

Patients and their families could give feedback on the service and their treatment. When needed, staff supported them to do this. Feedback postcards were the main source of feedback at the department. Managers clearly displayed the cards for patients and signs were available in the main corridor promoting the scheme.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. There were areas available where staff spoke with patients if they felt distressed. Staff knew what to do if a patient became unsettled during a scan and there were mechanisms to support patients during their scan to reassure them.

Staff recognised and understood the emotional impact undergoing diagnostic procedures might have on patients and supplied support. Staff also understood the social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Patients were given clear details of when results would be known and who to contact, to help minimise levels of anxiety while waiting for results.

Staff made sure patients and those close to them understood their care and treatment. Staff showed how they helped patients as part of their role. We observed care during the inspection where reassurance was given to patients on several occasions. The feedback scheme reinforced this with several patients expressing the kind approach taken by staff.

Good

Diagnostic imaging

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 diagnostic procedures.

Staff made sure patients and those close to them understood their care and treatment, and talked to patients, families and carers in a way they could understand.

Staff were aware of reasonable adjustments that could be made to ensure patients understood the information they were given. Staff could provide interpreters to support medical discussions. Staff at the department followed the hospital accessible information policy and provided information that met this standard.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The department had a patient survey which was visible through advertising and staff were proactive in directing patients to this. The survey was then analysed monthly.

Are Diagnostic imaging 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.

Patients gave positive feedback about the service. Patient survey data for the department was on average 99% positive in 2021.

Staff made sure patients and those close to them understood their care and treatment. Staff showed how they helped patients as part of their role. Several examples of feedback we reviewed praised staff on their engagement with patients during an appointment and their clear manner in explaining decisions for treatment. Patients described feeling empowered to make their own choices and that there was flexibility associated with this.

The department assisted the local NHS trust with oncology services and there was support given by providing dedicated capacity to the locations scanning services on a Thursday morning.

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.

Patient's individual needs were discussed during the booking of an appointment. Staff used the information to provide care and treatment in a safe way and mitigate any risk to the patient.

Good

Diagnostic imaging

Staff working in the department knew in advance which patients were attending scans that day. Patients requiring extra help or support were highlighted on pre assessment forms and measures were organised accordingly.

Signs let patients know hearing loops were available in the hospital. Staff supplied accessible information standard (AIS) leaflets for patients if they needed information on the facilities provided at the hospital. The department had an information accessible folder that also supplied details on translations services. Information leaflets were available on demand in a wide variety of languages and font sizes for patients to ask.

Managers made sure staff, patients, loved ones and carers could get help from interpreters including British Sign Language, when needed. Staff booking an appointment added translation needs on the booking system so that staff could act ahead of time.

Staff and managers laid out the department in a suitable manner and prioritised the safety of patients and staff. The department was laid out on one level and accessed by lift. Staff acted as chaperones where needed and were trained to do this. Individual changing facilities were available for patients for privacy and staff intervened and supported patients with mobility needs when this was required.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times for the service were not disruptive to patients care and treatment.

Patients were mainly self-funding or privately insured and booked their appointments via the hospital website or through the centralised administration team.

Staff did not discuss referral to treatment times in the department, but they were conscious that they were responsible for an integral part of the patient pathway. Managers did their best to provide prompt access to appointments. There was not a waiting list in operation at the department and managers told us that appointment availability had not been identified as a risk.

When appointments had to be cancelled, staff made sure they were rearranged as soon as possible and rebooked through a clinical priority triage process. Routine servicing of equipment was always planned to avoid disruption and unnecessary cancellation. Managers oversaw the equipment maintenance which was managed under a single servicing contract.

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 department received three complaints between February 2021 to January 2022. The highest number of complaints received in one month was two.

Managers investigated complaints and identified themes. Managers raised new complaints with senior managers during a daily communications call. This ensured senior managers had a recording of the complaint as early as possible. For wider details of the hospital complaint process please see the Surgery core report.

Good

Diagnostic imaging

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints and positive feedback were a standing agenda item for the department team meetings.

We did not speak to patients directly about their ability to make complaints, but we saw clear material in the department that explained the complaints process for patients. Examples of complaints that were responded to by managers of the department were reviewed following our visit and found to be managed in a suitable way.

Are Diagnostic imaging 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.

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.

Staff working in the department spoke highly about their managers and felt supported and valued. Managers were highly visible and approachable, and we saw evidence of this on the inspection.

Please see surgery core service report for wider details.

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.

Staff at the department understood the providers values and the direction the organisation intended to develop. A newsletter produced by the hospital allowed staff from the department to keep up to date with developments in the hospital.

Please see surgery core service for wider 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 patients, their families and staff could raise concerns without fear.

Good

Diagnostic imaging

Staff interviewed spoke in a positive manner about working at the department. Interactions between the manager and staff were professional with good body language observed. The department manager had been new in post and discussed with our team her own vision for the culture of the department where staff could feel comfortable to feed back any issues.

Please see surgery core service for wider details.

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.

There was a department meeting structure that was supported more widely by a hospital governance structure by a range of meetings. We reviewed meeting minutes from three meetings and staff could access minutes from these meetings. Staff could raise issues of concern from meetings to their line manager. The department manager represented the department at hospital level meetings including the daily communication calls and clinical governance meetings where diagnostic imaging input was required and could raise these concerns.

Please see surgery core service for wider details.

Managing risks, 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 department had a risk register which was updated regularly, with risks added to the register relating to patient care, safety performance and current issues.

Staff were aware of the risks associated with the department. The department had radiation protection supervisors (RPS) who met regularly and controlled radiation areas well. An audit programme following the IR(ME)R standards was in operation and suitable reports had been produced including the removal of hazardous waste. Minutes from a Radiation Protection committee meeting and MRI/CT evacuation training were seen by our inspection team.

Please see surgery core service for wider details.

Managing information

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 department ensured notifications were sent to external bodies when needed. The service leads knew when to submit incident notifications to regulators in line with IR(ME)R standards.

Policies and procedures that involved the management of information was available to staff electronically. Staff completed training in information governance and understood the importance of confidentiality of information. The department completion rate for information governance training was 100%

Good

Diagnostic imaging

Please see surgery core service for wider details.

Engagement

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

The department engaged with patients seeking feedback to improve the quality of the services provided. Patient feedback was shared with the team. It was used to improve the service. Staff knew how to support patients to give feedback and raise concerns.

Patient feedback was collected via a patient satisfaction survey which covered all areas of the hospital and aspects of care with recent results showing that service users rated provision as very good or excellent throughout.

Please see surgery core service for wider details.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

The department supplied four quality improvement schemes to review following the inspection. A staff mobility scheme was designed to utilise and empower existing staffing at the unit to improve resilience.

A CT Colonography service provision programme targeted an increase in appointment capacity through staff training and enhancement of their clinical scope.

A CT port accessing improvement project looked at training existing staff in conducting the procedure to reduce additional appointments at another location.

The DEXA service was evaluated using statistical analysis to optimise and target the most suitable referrals to the department.

Please see surgery core service for wider details.

Good

Medical care (Including older people's care)

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

Are Medical care (Including older people's care) safe?

Good

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

Mandatory training

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

The mandatory training was comprehensive and met the needs of patients and staff. Compliance rates for endoscopy and systemic anti-cancer therapy (SACT) services were 100%.

Mandatory training was a mixture of face to face and online. It included but was not limited to fire safety, consent, basic life support and equality and diversity. All staff had a role specific training matrix which was based on the training needs for their job role.

Systemic anti-cancer therapy (SACT) nurses had completed training in recognition and management of neutropenic sepsis. (Neutropenic sepsis is a potentially fatal complication of SACT). The provider monitored training compliance to ensure that practises followed current guidelines.

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 could explain how they would respond if they witnessed or suspected abuse; they would report the concern to one of the clinical service managers, who were the safeguarding leads.

Good

Medical care (Including older people's care)

Staff received training specific for their role on how to recognise and report abuse. 100% of staff had completed safeguarding adults' level one and two training. Managers made sure staff completed safeguarding training. This was monitored at local and corporate level.

Two of the clinical services managers were the dedicated safeguarding leads at the hospital. They were trained to safeguarding level four. Staff had access to support with safeguarding matters, this included out of hours support.

There had been no safeguarding concerns reported in the SACT and endoscopy services over the past year.

Cleanliness, infection control and hygiene

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

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

There was evidence of cleaning audits which helped to manage and improve staff compliance to infection control and hygiene. This included infection control audits of hand hygiene, clinical equipment such as central lines and cannulas, and use of personal protective equipment. The audits showed 100% compliance in endoscopy and except for cleanliness of patient equipment in endoscopy which had achieved 88% for the past three months. There was a clear action plan in place and staff were remined of infection control requirements in the morning huddle.

The access and flow of patients attending the units had been reviewed and the service had developed measures to manage the flow of patients whilst maintaining effective infection control processes during the COVID-19 pandemic.

There were established procedures to ensure that staff complied with the COVID-19 testing requirements to help prevent the spread of the virus.

Patient areas were clean and had suitable furnishings which were clean and well-maintained. Treatment rooms were clean and tidy. Chairs were clean and had easy to clean coverings. Some rooms had beds, and these were clean and well maintained. Flooring in all rooms was a laminate type which meant it was easy to clean.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw “I am clean” stickers on equipment.

In endoscopy staff cleaned equipment after patient contact. There was a clear clean to dirty pathway for the management of endoscopes. The bedside clean took place immediately after the procedure and this was followed by a manual clean of the endoscope. The endoscopes were sent to an off-site hub for decontamination and were packaged appropriately. Cleaning records were up-to-date and demonstrated all areas were cleaned regularly.

The clean and dirty flow for the scopes followed the process outlined in the national guidance. The hospital complied with the regulatory requirements outlined in the English Health Technical Memorandum (HTM) 01-06: Decontamination of flexible endoscopes.

In the endoscopy service the ventilation and airflow was monitored to minimise the risk of cross infection, in compliance with requirements.

There was regular water testing for legionella and bacteriological infections. The most recent Legionella test was completed in January 2021 with a clear risk assessment with actions which had been carried out.

There were handwashing sinks within the SACT and endoscopy services, with clear instructions for handwashing procedures.

There was an infection prevention and control link in both the endoscopy and SACT services who attended relevant hospital meetings and updated staff at department meetings.

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 systemic anti-cancer therapy (SACT) service comprised a pod with six treatment chairs as well as nine single treatment rooms with beds. Patients were allocated to a chair or bed according to clinical need. There was a reception and waiting area as well as two consulting rooms and a quiet room. The quiet room was used for having difficult conversations and could be accessed by patients and their loved ones as well as by staff who felt they needed some quiet time. There was a clinical room where medicines were stored. There were two storerooms which were clean and tidy, and which included stock lists so staff could see immediately what to find in there.

There were two patient toilets and one staff toilet. The skirting board in one of the patient toilets was loose and staff explained that this had been added to the risk register for repair and had been made safe in the meantime.

The endoscopy unit comprised two endoscopy rooms and a recovery area with six beds. The unit followed Joint Advisory Group on Gastrointestinal Endoscopy (JAG) guidelines, which included clean and dirty areas for endoscopes, a cleaning schedule, detailed pathways and checklists adapted from World Health Organisation. The recovery area was mixed sex and beds were separated by walls with curtains at the foot of each bed. Lists were split into male/female on the day to minimise mixed sex bed occupancy. This had been confirmed acceptable by JAG.

All patient treatment areas had call bells. Staff ensured that call bells were in reach and advised patients where the call bell was located staff responded quickly when called.

The design of the endoscopy and SACT services followed national guidance. The SACT service had been awarded the Macmillan Quality Environment Award. (The award champions cancer environments that go above and beyond to create welcoming and friendly spaces for patients.)

Staff carried out daily safety checks of specialist equipment. Equipment on the endoscopy unit and the SACT unit had an annual electrical check known as portable appliance testing. New equipment was asset tagged, sent to the facility department, and added to a specific register. This flagged when their annual reviews were due. All equipment looked at was stored neatly, was clean, dust-free and had the required up-to-date checks.

The service had enough suitable equipment to help them to safely care for patients. Patients in the oncology unit had access to a scalp cooler, and all staff were trained to use this equipment. (Scalp cooling can reduce hair loss caused by SACT). There was a system in place to ensure they were kept clean. There were weighing scales and machines to measure patients' vital signs. There was fully stocked resuscitation equipment available in both the endoscopy and SACT services. They were tamper-proof and included a list detailing the individual items that needed to be held. Staff replaced any used

items immediately or when they had past their expiry date. There was evidence of daily checks of equipment and consumables which were all in date. Resuscitation guidelines were attached to the resuscitation equipment to helpsupport staff in an emergency. The SACT service also had ready made up packs for use in the event of specific clinical needs such as neutropenic sepsis and vascular occlusion. The packs included appropriate equipment and guidelines and meant staff could react promptly and confidently in the event clinical emergencies. There were clear flow charts to help staff make prompt clinical decisions based on national guidelines.

The endoscopy and SACT services had suitable facilities to meet the needs of patients' families.

Staff disposed of clinical waste safely. They used a colour coding guide to separate waste for disposal, in line with national guidance. There was a poster displaying their guide. Sharps such as needles were disposed of in line with national guidance. Sharps bins were stored safely in designated secure areas until collected.

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.

Patients were assessed medically for their endoscopy by their consultant at their outpatient appointments and by the nursing team at their pre-treatment assessment to check their fitness for the procedure. The pathway provided prompts of the observations that should be undertaken. We checked two set of notes for patients who had endoscopy procedures. Staff had recorded observations of the patients' pulse rate, oxygen saturations, respiratory rate, temperature and blood pressure. These observations helped staff to identify early signs of patients' deterioration.

Endoscopy staff used the World Health Organisation (WHO) guidelines five steps to safer surgery to ensure compliance. Their audit results for compliance with the WHO checklist were 100% in January 2022. The hospital complied with the WHO checklist.

Systemic anti-cancer therapy (SACT) nurses completed an assessment in advance of commencing SACT including blood tests, height and weight. Results of these assessments were reviewed by the patient's consultant to confirm suitability for treatment as part of the treatment care pathway. During the assessment patients were given information about the risks of SACT and how these risks could be managed as well as follow up appointments and support. Standard protocols were used to allow patients to access their specific prognostic indicators.

Systemic anti-cancer therapy nurses used the United Kingdom Oncology Nursing Society (UKONS), triage tool. They provided on call cover and could use the triage tool with patients who had received SACT. An out of hours telephone assessment and triage of patients who may be suffering from side effects of SACT was available and nursing staff contacted the consultant if triage indicated the patient needed emergency care or to be admitted to hospital. The assessment supported oncology staff to recognise emergencies and potential emergencies to ensure that appropriate interventions were arranged. If the patient's consultant was not available staff would contact the resident medical officer by telephone. There was a transfer agreement with a nearby NHS trust and in place to support patients who became unwell during their treatment. There were five transfers in the last 12 months and all of these were safely managed with and on an appropriate pathway for the patients.

Good

Medical care (Including older people's care)

Systemic anti-cancer therapy and endoscopy huddles took place in the departments at the beginning and end of each day when staff discussed the patients attending, treatments and concerns.

Staff considered sepsis and the signs of sepsis as part of their assessments, in line with the UK oncology nursing society (UKONS). If patients presented with possible sepsis while at home, there was a clear risk assessment in place to triage patients according to clinical need.

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.

The service had enough nursing and support staff to keep patients safe. Nursing staff levels and skill mix were planned according to patient admissions which were known in advance.

The SACT service was managed by a clinical services manager, a deputy clinical services manager and a SACT sister. There were three clinical nurse specialists whose role was to offer holistic care to patients. There were five senior staff nurses, one staff nurse, one senior health care assistant, two health care assistants and two patient administrators. The staff nurse and health care assistants were taking part in developmental pathways to more senior roles. Consultants attended the service for appointments with patients 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 endoscopy service was managed by the theatres clinical services manager. There was an endoscopy lead, two senior practitioners and two endoscopy nurses.

There were no vacancies in the endoscopy and SACT services and sickness rates were low. The SACT service used one regular bank nurse if needed. The endoscopy unit had not used bank or agency staff in the past year.

There was an on-call consultant during evenings and weekends. Staff reported they could always reach a consultant for advice at any time, but they rarely needed to contact them. Staff said they had not had any trouble contacting consultants.

A resident medical officer (RMO) provided 24-hour, seven day a week cover at the hospital. They provided medical care to patients at the hospital during the day and out-of-hours.

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.

Patients' notes were comprehensive, and all staff could access them easily. Staff had access to patients' records including results of tests to provide safe and effective care. Patients' records were detailed and included diagnosis, their findings and treatment plan.

Patients' records also included care pathways, past medical history, risk assessment, consent form, observations, medicines and discharge plan. Endoscopy records included an adapted world health organisation (WHO) five steps to safer surgery checklist.

Good

Medical care (Including older people's care)

Records were stored securely. Patient records were kept both electronically and on paper. Staff reported the service were planning to use an electronic system in the future. The paper records were stored in lockable filing cabinets. In the SACT service there was a treatment board to notify staff of patients attending for treatment that day as well as any patient related tasks. The board was updated at handover and regularly throughout the day and was in the clinical room.

Following completion of any treatment or procedure, a report was sent to the patient's GP and a copy was also given to the patient on discharge. Staff kept detailed records of patients' care and treatment.

We reviewed six sets of patient records across the two departments and found them to include the relevant assessments of care needs, risk assessments and were patient centred and personalised.

Medicines

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

Medicines were securely stored within their recommended temperature ranges in both the endoscopy and oncology units. All medicines were stored neatly with drugs in date and documentation completed correctly. Medication fridges were locked when not in use and checked daily to make sure they were within the correct temperature range. Fridge temperature records we reviewed confirmed this.

Controlled drugs were stored securely and managed in line with the hospital-controlled drug policy. There was a controlled drugs accountable officer in post.

Patients attending the systemic anti-cancer therapy (SACT) service received intravenous treatments. Injectable SACT was supplied pre-prepared to the pharmacy department at the hospital.

Staff followed systems and processes to prescribe and administer medicines safely. The dispensing process was managed well. The hospital had a designated pharmacist for the management of oncology medicine. SACT was stored in a designated area which included a fridge, and this was kept separate from other medicines. SACT used in the oncology service was prescribed through an electronic prescribing system. All prescriptions for cytotoxic SACT was verified by the oncology pharmacist in line with local policy to ensure calculations, drug dose, route, timing and scheduling were correct. We saw oncology nurses using the electronic prescribing system to perform checks and record administration.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. There were regular medicine reconciliation audits which showed 100% and 99% compliance for endoscopy and SACT respectively.

The pharmacy team supported the delivery of effective medicines management. However, there was no lead pharmacist in post and the pharmacy team had not held team meetings or attend other departmental meetings for since November 2021, when the previous lead left the post. There had not been any incidents relating to this. Leaders told us they had successfully recruited to the lead pharmacist role, and the post would be filled within two months.

The endoscopy and SACT services did not use patient group directions (PGDs). PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber.

Incidents

Good

Medical care (Including older people's care)

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

Staff knew what constituted an incident and how to report them. Staff raised concerns and reported incidents and near misses in line with provider policy, using an online incident reporting system which guided staff through the reporting process. Staff were required to make recommendations for solutions when reporting an incident.

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

Incidents and any improvements to patient care made following incidents were discussed in the morning huddles. Managers debriefed and supported staff after any serious incident.

There were no outstanding incidents in SACT and endoscopy on the day of inspection. There had been 90 reported incidents in the location in the past year and all of these were low or no harm. We requested information relating to themes and trends of incidents but did not receive this information from the provider. There had been no serious incidents or never events reported in the SACT service and endoscopy unit in the last year.

Staff understood duty of candour. Staff were aware of their responsibility to inform patients when anything went wrong. We saw written evidence of duty of candour including what had gone wrong, details of the investigation and resulting outcome.

Are Medical care (Including older people's care) effective?

Good

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

Evidence-based care and treatment

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

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. New policies were disseminated to staff through email and discussed in team meetings when staff were alerted to policy updates and ensure they had accessed them.

Good

Medical care (Including older people's care)

Endoscopy patients were given information and staff followed fasting guidelines in line with the Royal College of Anaesthetists and National Institute for Health and Care Excellence (NICE). The endoscopy service followed the Health Technical Memorandum 01-06 (HTM) for the decontamination of flexible endoscopes, which included cleaning and high-level disinfection at the end of the decontamination process; and maintained in a clinically satisfactory condition up to the point of use.

Screening for neutropenic sepsis was carried effectively, in line with UK Sepsis Trust guidance. The provider followed local sepsis management protocols. There were sepsis management grab trays, which consisted of a checklist along with all equipment required to make a diagnosis of and to treat suspected sepsis.

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 attending the systemic anti-cancer therapy (SACT) service were given lunch and drinks were available throughout the day.

Specialist support from staff such as dietitians and occupational therapists was available for patients who needed it. Staff could refer patients to these services when needed.

Patients' nutritional status was assessed when they attended for treatment and staff provided advice and support to maintain a balanced diet.

Staff in endoscopy followed fasting guidance and information was shared with patients to ensure their procedures could be carried out safely.

Patients were given appropriate medicine to help prevent nausea and vomiting both during their endoscopy procedure and during and after their SACT treatment.

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.

Patients undergoing an endoscopy were offered a throat spray to reduce discomfort and/or intravenous sedation, to minimise any discomfort or pain.

Staff in the SACT service monitored patients' pain when they received systemic anti-cancer therapy. Patients received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately. Patients were given pain relief to take home, where appropriate.

Patient outcomes

Good

Medical care (Including older people's care)

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

The endoscopy service achieved accreditation with the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) with the most recent review in January 2022. JAG accreditation provides independent recognition that a service demonstrates high levels of quality by following specific safety guidelines.

Systemic anti-cancer therapy nurses and consultants monitored individual patients' outcomes as patients returned for review and further systemic anti-cancer therapies. This was recorded in patients' medical notes. The service contributed to the Private Healthcare Information Network (PHIN).

The SACT service participated in regular audits of the United Kingdom Oncology Nursing Society (UKONS) triage tool forms used. We reviewed the audit undertaken of the UKONS management guidelines tool completed in 2021. The data submitted by the hospital stated that the hospital was 95% compliant.

There was a protocol in place for the use of ports and catheters to make SACT treatments easier and potentially reduce the risk of infection.

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.

All new staff received a full induction tailored to their role. The induction included a mix of training, protected time for review of policies and procedures and clinical work under supervision. Staff were supernumerary during this period.

Managers supported staff to develop through yearly, constructive appraisals of their work. All SACT and endoscopy staff had received an annual appraisal within the expected time frame. Nursing staff were given support and protected time to complete their revalidation.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Staff met with their line manager every month for regular check ins. Staff felt managers were visible and told us they could check in between their monthly had an open-door policy.

Managers made sure staff received any specialist training for their role. Endoscopy nurses received training in cannulation. Systemic anti-cancer therapy nurses attended the required competencies to be able to administer systemic anti-cancer therapy (SACT). They had to complete regular SACT training to be able to administer SACT medication via the intravenous, sub-cutaneous and intramuscular and oral routes.

All nursing staff at the unit have been assessed using the national UKONS SACT Passport. The passport was developed with input from clinical specialists and an oncology patient to ensure SACT training is consistent, up-to-date and standardised knowledge and best practice. It enabled staff to better help patients and their families manage both the psychological and the physical effects of SACT

Staff were actively supported to progress. We were given several examples from housekeepers to senior staff members who had been supported to achieve career progression goals. Three nursing staff in the SACT service were taking part in a developmental pathway to enable them to advance their skills and progress to more senior roles.

Multidisciplinary working

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

There were effective multidisciplinary teams in the endoscopy and SACT services. There were morning and afternoon huddles in both services, and these were attended by nurses, consultants, pharmacy, and administration staff.

There were weekly multidisciplinary meetings to discuss patients being treated in the service and these took place at a local NHS trust. The meetings had continued virtually during the pandemic. They were chaired by one of the medical team and attended by the named consultant, clinical nurse specialist(s), radiologist and histopathologist. Consultants presented an overview of their patient and the group discussed the patient's diagnosis, test results, pain relief, progress, treatment and general wellbeing and support. We did not ask to see the minutes of these minutes, but we were told the meetings were effective and that all members were valued and confident to contribute.

The clinical nurse specialists helped to prepare patients with cancer for surgical treatment. This helped to provide continuity of care and support. They also provided post-operative support and care.

The team utilise a "track and trigger" system for patients receiving palliative SACT. The clinical nurse specialist (CNS) team triaged patients that may benefit from a formal assessment of palliative care needs in the community. This included intervention and/or onward referral to other health professionals or teams. This information was shared in morning huddles by the CNS to the rest of the SACT team.

GPs received written information about a patient's endoscopy procedure or systemic anti-cancer treatment. This included what advice the patient had received for their ongoing care.

Systemic anti-cancer therapy patients were discussed in a multidisciplinary team meeting which took place at a local NHS hospital and which was attended by members of the multidisciplinary team such as consultants, nurses, physiotherapists, pharmacists and occupational therapists and which provided opportunity for peer review and benchmarking.

Seven-day services

The oncology and endoscopy services did not provide a seven day service.

The endoscopy procedures were planned, and sessions were available Monday to Friday from 8.30am to 6pm.

The Systemic Anti-Cancer Treatment (SACT) service was available from Monday to Friday from 8am to 8pm. However, opening times were altered where appropriate to meet patient need, including a weekend service as required for port removal. The SACT service also provides a 24 hour seven days a week triage service accredited by UKONS. Outside these hours there was an out of hours on call service where patients could telephone and speak to an oncology nurse if they needed help or advice.

Good

Medical care (Including older people's care)

Staff could call for support from consultants, 24 hours a day, seven days a week. A resident medical officer was available seven days a week and provided on call cover for out of hours.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Systemic anti-cancer therapy (SACT) staff used a holistic pre-treatment assessment form which included the patient's mental capacity, skin integrity, nutritional needs as well as spiritual and psychological needs. This was reviewed by the consultant and followed by a consent form which was completed by the patient and consultant agreeing to the proposed treatment plan, prior to the first treatment.

For patients with reduced mental capacity, such as those with dementia or learning disabilities, a best interests decision was made on their behalf. A best interests decision is made by applying the Best Interest principle, as set out in the Mental Capacity Act 2005. After each treatment the SACT staff completed an evaluation of care record and at the end of the last treatment an evaluation of care record and a follow up holistic assessment form were completed. The original copies were filed in the patient's notes and a copy given to the patient. A photocopy of the consent had to be given to the patient. Secondary consent had to be obtained before the administration of SACT and signed on the consent form. The SACT nurse discussed potential adverse outcome and complications of both systemic therapy and oral treatments.

Staff made sure patients consented to treatment based on all the information available including discussions about treatment options and prognosis. Sperm banking or egg freezing was discussed with relevant patients prior to booking treatment, unless their clinical condition dictated otherwise. This discussion included the implications on fertility along with the risks that toxic body fluids contain during intercourse with partners.

In endoscopy staff explained the procedure fully to patients before the procedure and the consent form was completed during the pre-operative checks. We observed staff checking to make sure patients understood the procedure fully. Consent was recorded in the pre-operative checklist. During the procedure staff checked with the patient to make sure they were comfortable and happy to continue.

Are Medical care (Including older people's care) caring?

Good

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

Compassionate care

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

Systemic anti-cancer therapy (SACT) patients said staff treated them well and with kindness. One patient told us the staff felt like family to them and another said they always made them feel better and brightened their day.

Good

Medical care (Including older people's care)

Systemic anti-cancer therapy staff supported patients who became distressed and used a specific room to break bad news and for patients in distress.

In the endoscopy unit a dignity champion was appointed for each procedure. Endoscopy patients were given privacy to change. Systemic anti-cancer therapy patients were allocated to private rooms or to a bay with six chairs with privacy screens. Patients were asked if they would like a chaperone during consultant appointments.

All SACT chairs/rooms and endoscopy rooms had call bells. Staff were alerted to patients who had used their call bell by a light which displayed outside their room. It also flagged on the display panel behind the staff reception desk.

The service used patient satisfaction questionnaires to identify areas for improvement. The majority of patients who completed the questionnaires rated their personal experience as “excellent".

Hospital wide patient survey results showed patients felt always their privacy and dignity were respected. These results were not specific to SACT or oncology, but overall results for patients who had attended the hospital.

Please see Surgery section for further information.

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 their loved ones help, emotional support and advice when they needed it. One patient told us that during the early days of the Covid-19 pandemic, patients’ wider circle of family and friends were encouraged to speak to those attending for systemic anti-cancer therapy (SACT) by video link and that this helped to reduce anxiety during treatment. We observed staff interacting with two patients in endoscopy and one patient in SACT. All three were treated kindly and with care to help to reduce anxiety.

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. Complimentary holistic treatments, such as massage, acupuncture and reiki, were available in the SACT service and each patient could access one treatment per week.

Staff provided holistic assessments and advice prior to patients commencing systemic anti-cancer therapy. For example, they discussed the potential impact of treatment on their sexuality and reproduction. They gave advice and information such as hair care, wig providers and discussed individual concerns related to self-image and self-esteem.

Senior leaders worked in a patient facing role for a day to identify areas for improvement. For example, during the COVID-19 pandemic, when visitors were not allowed, a patient explained the comfort that their relative brought during their SACT. This was observed by a senior leader who then revisited the risk assessment to allow one visitor per patient to attend during SACT.

Understanding and involvement of patients and those close to them

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

Good

Medical care (Including older people's care)

Staff made sure patients and those close to them understood their care and treatment. Staff involved patients' loved ones and cared for patients in a holistic way. For example, during the COVID-19 pandemic, when loved ones were not permitted to attend the service, a patient became worried for their partner who was waiting in the car. Staff visited the partner with a hot drink and some lunch, and which alleviated the patient's concerns.

Staff supported patients to make advance decisions about their care. Patients received information to support them in understanding how to manage their condition. For example, they discussed advance care plans prior to commencing systemic anti-cancer therapy. Systemic anti-cancer therapy patients were given information to help them recognise potential side effects from treatment and how these should be managed.

Are Medical care (Including older people's care) responsive?

Good

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

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

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

The hospital had achieved JAG accreditation in 2020.

The oncology service was awarded the Macmillan environment quality mark (MQEM). This is a detailed quality framework, used for assessing whether cancer care environments meet the standards required for people living with cancer. The MQEM assessed four main areas of the cancer services including clear wayfinding for visitors, welcoming and ascetically pleasing reception and waiting areas, and access to private consultation rooms. The assessment also included the patient's journey to and from the hospital. For example, the cost and availability of parking, how easy it is to get to the facility on public transport, internal facility signposting and flexibility in making appointments.

The pre-treatment assessment looked at access to cancer-specific information and health professionals, choice and range of food available, cleanliness and tidiness of facility.

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

Meeting people's individual needs

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

The endoscopy and oncology patients' individual needs were discussed during booking and pre-admission assessment. This information was used by staff to provide care and treatment in a safe way and mitigate any possible risk to the patient. If during pre-admission assessment, staff identified the service could not meet the patient's needs, staff would

not treat the patient at the hospital and refer the patient to an alternative health care provider who could support the patient. The hospital did not have the facilities to support the care of patients with complex needs. Therefore, this patient group was not admitted to the hospital. However, patients who had a learning disability or dementia could be admitted but only after the appropriate risk assessments and mental capacity assessments had been carried out.

Patients received written information ahead of their appointment which included specific instructions and information about what to expect as part of their care and treatment. This included information leaflets explaining different endoscopy and systemic anti-cancer therapy (SACT) procedures. These leaflets were designed to address patient's questions about their forthcoming procedures.

The environment was designed to meet the diverse needs of needs of patients. People with limited mobility and wheelchair users could easily access all areas of the service and there was a passenger lift suitable for wheelchairs.

Managers made sure patients and loved ones could get help from interpreters or signers when needed. The hospital had collated a list of employees who could act as translators and interpreters if needed. They could also book interpreters in advance of appointments using a service that offered phone interpretation. Staff told us there were few requirements for these services as most of their patients spoke English.

All patients had a named consultant who attended the SACT service to review their patients. Patients also attended appointments with clinical nurse specialist in advance of their treatment for cancer and clinical nurse specialists worked jointly with named consultants to support patients receiving a distressing diagnosis. They discussed patients together and in advance of appointments. They followed patients up after they received bad news and offered on-going support. They did not offer follow up support for NHS patients after they were discharged from the hospital. However, they liaised with NHS specialist staff to provide effective handover of care.

Staff in SACT and endoscopy provided patients with information at the end of their treatment or procedure, should they have any concerns after they had left the hospital. They gave them information about the signs and symptoms to look out for following systemic anti-cancer therapy, and what they could do to relieve them. They also gave them out of hours contact details in case of concerns. Patients using the out of hours service were directed to the local NHS accident and emergency, if appropriate, and an arrangement was in place to send full details of the patient's diagnosis and treatment as well as alerting the consultant.

Patients requiring palliative care were cared for jointly with the local community palliative care teams. There was a clinical nurse specialist for end of life care whose role included liaising with the community teams.

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

Patients had access to complementary therapies on four mornings per week to help support patients' psychological wellbeing. These included massage, reiki, counselling and dieticians.

Access and flow

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

The hospital offered a flexible service that included variable appointment times and choices regarding when patients would like their treatment, subject to consultant and nurse availability.

Good

Medical care (Including older people's care)

The hospital had established a clear booking process for appointments and hospital admissions. Patients we spoke with told us the hospital had a good and efficient booking process and they did not have to wait for treatment. Oncology patients booked their treatment appointments directly with the oncology team rather than through the booking team.

The endoscopy service had enough decontaminated endoscopes to enable the scheduled endoscopy lists to proceed uninterrupted. This met the standards set by the Joint Advisory Group (JAG) on gastrointestinal endoscopy. Further endoscopes were available to access if required.

Consultants saw patients who were referred by their GP as an outpatient before an endoscopy procedure. They checked they met the admission criteria, assessed patients and discussed a plan of treatment. Consultants undertook endoscopies according to a patient pathway, minimising the time patients waited for treatment and care. Staff planned for the flow of patients.

Consultants referred SACT patients following diagnosis through either an NHS hospital, or in a private outpatients' setting. The consultant outlined the proposed treatment plan for the patient.

Endoscopy and oncology procedures were day-cases but both types of patients could be admitted to the inpatient ward and stay overnight if the need arose. For example, if the patient was frail or nauseous or had no support at home. We were given examples by staff when this had happened.

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 were encouraged to leave comments and feedback via the company patient satisfaction survey. Complaint forms were on display in patient areas within the SACT and endoscopy services. Patient feedback was on display in the endoscopy unit and at the entrance to the SACT service. This included individual comments, themes and overall results. Details of how to make a complaint were not displayed in the SACT service. We addressed this with the SACT team and details of the complaints process were placed in reception and the waiting room immediately.

Staff explained the complaints process and how they would listen to the patients' concerns to try and resolve the issue themselves but would seek support from their line manager if needed.

There had been one complaint reported to the SACT service and no complaints reported to the endoscopy service over the past year. The provider acknowledged all complaints, both verbal and written. All complaints were logged in order to ensure the investigation and response was managed in line with policy. The endoscopy and SACT services combined had received 38 compliments over the last year.

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning from complaints was shared with staff through emails and team meetings. Staff gave examples of how complaints had been resolved and used to improve patient care and experience.

There had been no complaints relating the SACT or endoscopy referred to the Independent Sector Complaints Adjudication Service (ISCAS). This is voluntary subscriber scheme for the independent healthcare providers which supported patients and provided independent adjudication on complaints.

Good

Medical care (Including older people's care)

Complaints were discussed at the monthly clinical governance meeting and heads of department meetings. The endoscopy and SACT clinical services managers attended these meetings. Lessons learned were shared with staff.

Are Medical care (Including older people's care) well-led?

Good

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

Leadership

Leaders had the skills and abilities to run the service. They 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 senior leadership team at the hospital included the executive director and the director of clinical services. They were responsible for the day-to-day management and development of the hospital. Staff told us leaders were visible and approachable.

The theatre manager had overall responsibility for the endoscopy department. However, the endoscopy department was managed day-to-day by the endoscopy lead nurse.

The oncology service was managed by the cancer clinical services manager, who was also the national lead for cancer services at provider level.

The endoscopy lead and systemic anti-cancer therapy (SACT) nurses felt well supported by their managers. During our inspection we could see the close working relationship between managers and their team.

The leaders in the SACT service had asked staff to establish a set of 'new year's resolutions' for them to adhere to which staff felt would improve their leadership of the service and for which leaders were accountable. These included consistency of leadership styles, praising staff for good work, increased one to one support and continuation of the establish culture of incident reporting. The outcome of these measures was included in the staff feedback survey.

Please see Surgery section for further information.

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.

The purpose for the Circle Health Group was to provide the high quality, safe, accessible and affordable healthcare in a sustainable way.

The aim for the hospital was to be the most innovative and patient focused healthcare organisation, and by equipping their outstanding people with leading technology, delivering the highest quality care.

Good

Medical care (Including older people's care)

Please see Surgery section for further information.

Culture

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

Staff we met during our inspection were welcoming, friendly and helpful. We spoke to staff across various grades and disciplines. Staff told us they were proud to work for the provider. The SACT and endoscopy staff described healthy working relationships where they felt respected and able to raise concerns without fear. Staff told us the culture was one of learning and they were encouraged to be open and honest with patients and colleagues when things went wrong. There was also a template for celebrating successes in place which staff told us was popular and motivating.

Working hours were tailored to staff personal preferences where possible.

Staff told us they were most proud of their incident reporting culture, which encouraged staff to come forward when things went wrong and to identify recommendations for improvement.

Please see Surgery section for further information.

Governance

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

The hospital's clinical governance committee met monthly. Audit, action plans, training compliance, policy reviews/ updates, complaints and user feedback were regular agenda items. The committee had staff representation from clinical areas. The theatre manager was responsible for ensuring issues relating to governance in endoscopy were raised at the clinical governance committee. The cancer clinical services manager was responsible for ensuring issues related to governance in SACT were raised.

Leads disseminated information to clinical areas. For example, key information such as lessons learnt, policy updates and patient feedback were highlighted on information boards in clinical areas. This included the endoscopy and SACT services. The committee supported safety and quality of clinical care and ensured staff were able to learn about the quality of the service.

There was a systematic programme of internal and external clinical audit to drive improvement. This included participation in the provider's national audit programme. The hospital used an audit calendar to ensure audits were completed within expected time frames. They completed an action plan if there was non-compliance with any audit standards.

There was an endoscopy specific user group at the hospital which was chaired by a consultant endoscopist. Attendees included the hospital executive director, director of clinical services, deputy clinical services lead, infection prevention and control lead and quality risk manager. The meetings were held every three months. Endoscopy and SACT staff also held team meetings every month.

Good

Medical care (Including older people's care)

The hospital had a medical advisory committee. They met quarterly and included consultant representation for SACT and endoscopy. They considered and made recommendations to the hospital board on matters pertaining to the medical staff. This included the appointment or reappointment of all members of the committee.

Please see Surgery section for further information.

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 hospital wide risk register. Risks were categorised as very low, low, medium or high. There were no open risks determined as high on the register in the SACT and endoscopy services. Leaders could cite the current risks which included wastage of SACT, return to face to face meetings and reduced capacity in meeting rooms and décor.

There was a systematic corporate programme of clinical and internal audit to monitor quality, operational and financial processes at the hospital. We could see the endoscopy and oncology services carried out these audits and, identified and took action where required.

Please see Surgery section for further information.

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 hospital used computer toolkits and dashboards to collect and monitor data throughout the hospital including the endoscopy and oncology services. Data on staffing, quality and safety was collected, reviewed and used to drive improvements in care.

Staff completed training in information governance.

Clinical staff could access information using a computer with individual log in details which enabled them to access patient information such as referral letters, blood test results, x-rays and other investigation results.

Discharge letters were sent to GPs. They included the reason for treatments and procedures, findings, prescribed medication, any medication changes and details of follow up. They also placed a copy of the letter in patients' medical records at the hospital.

Staff could access information on the hospital intranet. This included clinical policies and standard operating procedures. Please see Surgery section for further information.

Engagement

Good

Medical care (Including older people's care)

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

Patients were encouraged to leave feedback using a patients' satisfaction questionnaire which were available in the SACT and endoscopy services as well at the hospital reception. Patient feedback was reviewed at clinical governance meetings. We did not see results specific to endoscopy and SACT.

The hospital also collected patient feedback on specific issues such as décor. For example, in the SACT service, patients were asked to vote on their preference of three new chairs in the waiting room and the favourite was ordered for the waiting room seating.

The CNS team had access to standardised palliative care update forms designed to support hand over to community palliative care colleagues. This was introduced as a quality improvement initiative following a review of an expected patient death.

The hospital collected annual feedback from staff and compared the results against other locations under the same provider. Staff were asked to comment on themes such as leadership, personal growth and wellbeing. The results were reviewed at the monthly clinical governance meetings and an action plan was completed to address issues and maintain good practice.

Please see Surgery section for further information.

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.

There was a culture of quality improvement, staff were encouraged to report incidents and concerns while also making recommendations for improvements.

The SACT team had developed a system to improve timely diagnosis and treatment of neutropenic sepsis. (neutropenic sepsis is a potentially fatal complication of SACT treatment). This included analysis of risks and incidents over a two year period to November 2021. Quality improvements included: example completed forms added to the sepsis pack, for staff to use as a template; contact numbers for relevant staff such as microbiology; and posters to alert other staff when there was a clinical emergency taking place.

The oncology nursing team introduced a pilot to test whether lower SACT infusion rates reduced patient reactions to the therapy. Reactions to SACT infusions are a known complication of the therapy and can result patient deterioration. The pilot resulted in significantly reduced SACT reactions. The team created SACT rate charts to enable the whole team to manage and monitor outcomes effectively. Results had been shared with other Circle Health Group oncology centres across the UK.

The oncology clinical services manager, who was also the national cancer lead for the provider, was part of a multi provider collaboration to develop a matrix of cancer standards. The completed work had recently been sent for publication and national recognition.

Good

Medical care (Including older people's care)

The endoscopy team had developed a quality improvement initiative to improve the cleaning process for nasoendoscopes using colour coded bags to visually highlight whether an endoscope was clean or dirty. This meant the clinical team were assured and could see at a glance which equipment to select for use.

Good

Outpatients

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

Are Outpatients safe?

Good

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

Mandatory training

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

At our previous inspection, there were concerns regarding the completion rate of mandatory training in the department. Figures seen for the department were above the hospital target and represented a big improvement.

Staff kept up to date with their mandatory training. The most recent figures showed 95% of clinical staff and 94% of non-clinical staff completed their mandatory training. This was higher than the corporate target of 90%. One staff member had recently joined the team and recently began the training which affected the scores.

The mandatory training was comprehensive and met the needs of patients and staff.

Managers checked mandatory training completion and alerted staff when they needed to update this. Managers had suitable oversight of the mandatory training using a training matrix that showed the mandatory training status for each staff member and the status of each individual module. Managers individually reminded staff to complete upcoming mandatory training. Managers followed up and supporting staff who had not completed training on time.

Clinical staff completed training modules on recognising and responding to patients with dementia.

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.

At our previous inspection, we had concerns about child safeguarding training not being at Level three. At this inspection, it was confirmed by the department that they no longer see children, but that staff have retained their child safeguarding training at level two in case children attended an appointment with their parent.

Good

Outpatients

A safeguarding lead for the department supported staff. Staff trained at level two or three in adult and children safeguarding courses depending on their level of clinical responsibility. The department had a 100% completion rate for training.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with showed a good knowledge of what actions they would take if they had concerns.

Staff could recognise adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff could access contact details of the local safeguarding teams and find the safeguarding policy of the hospital.

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 including consultation rooms were clean and furnishings were well-maintained. New sinks were installed in the all consultation rooms to enhance Infection Prevention and Control (IPC) compliance with government guidance.

Staff completed IPC training and managers nominated an IPC link for the department, holding responsibility for the oversight of IPC processes. Concerns would be brought to the IPC nurse of the hospital using a hospital wide audit tool.

Staff kept up to date cleaning records which demonstrated all areas of the department were cleaned regularly. The IPC lead audited cleaning checklists conducted by staff at the department. Deep cleaning of the department occurred a week and records supported this.

Staff followed infection control principles including the use of personal protective equipment (PPE). PPE was readily available, and staff were observed following guidelines around the safe application and removal of PPE.

The department scored 73% on its most recent IPC standard precaution audit (November to December 2021). This was lower than the previous audits scores over the previous three months and worse than the provider target of 95%. Managers had created an action plan to improve this. Despite this, the department scored 93% on a December 2021 IPC audit of patient equipment which showed actions plans were demonstrating the needed improvement.

Environment and equipment

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

The design of the environment followed national guidance. The department was positioned next to the main reception and based on one floor. Managers split the department reception desk for outpatient bookings into two compartments by using partition screens protecting the receptionist and patients and following Covid 19 guidance. Receptionists were available to process and welcome patients. Staff gave patients a nominated place in the waiting room to sit that was labelled with their individual consulting room. The nominated places were socially distanced with two chairs, a table and a label indicating the consulting room they would attend. The waiting area was open with a TV operating advertising material for the provider. The waiting room had a water and coffee machine available for patients.

Managers conducted risk assessments for the health and safety of the building and staff. Managers completed the last assessment in December 2021 for the department which did not find concerns.

Good

Outpatients

An external company completed electrical safety checks for all equipment in the department annually. Staff felt they had enough suitable equipment to help them to safely care for patients. Staff stored stock in a suitable manner. Staff stored consumables neatly in trolleys, consulting and treatment rooms. Consumables we checked in the outpatient department were in date and there was evidence of stock rotation.

Staff disposed of clinical waste safely after each clinic. Staff labelled sharps bins correctly and did not overfill them. Staff emptied waste bins after each clinic and stored it securely until collected by an external supplier whom the hospital contracted to dispose of clinical waste. Clinical waste bins were open in the outside storage area, but managers had risk assessed this and provided a documented assessment for the area with a suitable rationale.

Assessing and responding to patient risk

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

At our previous inspection, we held concerns about the assessment and response to risk in the department not being at a suitable level. We did not see any evidence of poor risk assessment of patients at this inspection and we found that the previous raised concerns were resolved.

Staff knew in advance which patients were attending the department. Patients requiring added help were identified during the booking of their appointment. This could include, but was not limited to mobility, sight and hearing requirements.

Staff responded promptly to any sudden deterioration in a patient's health. There were pathways for identifying and managing deteriorating patients. Alarms were operational in each consultation room. Staff could call a specific number to summon emergency support from the wider hospital when required. Staff we spoke with knew what actions to take and who to escalate their concerns to. Staff had training in immediate life support which included basic life support (BLS) training to ensure they had the skills to identify a deteriorating patient.

Staff ensured a resuscitation trolley for adults in the department was available and held the needed equipment and stock. Staff completed stock checklists associated with the trolley. Staff tested and demonstrated the defibrillator for us to ensure it worked correctly. The defibrillator had defibrillator pads for adults that were in date.

Staff assessed risks associated with minor procedures in the department. World Health Organisation (WHO) surgical checklists were reviewed and completed fully.

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.

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

Managers felt they had enough staff to keep patients safe. Managers took part in a daily communication call each day where hospital departments reported the number of staff on duty and reported risks associated with this. Managers had rosters arranged for the department in advance. Staff we spoke with were positive about how the department was staffed and there was enough staff with the right skill mix to cover clinics so that patients could see a suitable clinical member of staff.

Good

Outpatients

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift. Managers had rotas that looked at the capacity needs of the department over a three-month time period.

Managers made sure all bank and agency staff had a full induction and understood the service. The department had used agency and bank staff in the past year. Managers completed an induction checklist relevant to the location with locum staff. This included making staff aware of any location specific information. We saw a copy of the locum induction to confirm this.

The service offered practicing privileges to consultants. Practicing privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic, in independent private practice, or within the provision of community services.

Records

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

Records were securely stored when not being used in the department. Staff stored patient notes in a separate locked area to the outpatient department area. Staff working in the department only had access to patients' records for the clinics running that day.

Staff transferred records to the department where they were stored in a designated position of the nurse's office. Staff leading the running of the clinic would collect the files and return them following the clinic. Staff locked this office when there weren't staff present. All records used are paper based, but the hospital was is in the early stages of moving to an electronic record system.

Patient records seen on the day of inspection had limited information at the time we viewed them. We saw a hospital wide health documentation audit which showed a score of 97% between August and November 2021. This audit looked at accuracy, safety and security of individual records audited. A cosmetics audit was also reviewed that looked at medical records where clinical procedures were proposed. The results were 75% measured against their own quality framework and improvements had been identified by the hospital with evidence of action being taken. We also reviewed a number of surgical checklists which were completed fully. Due to this evidence, we were assured that records were complete in their detail and that actions were taken by the hospital when needed.

Medicines

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

Staff managed medicines and prescribing documents in line with the hospital policy. Staff checked emergency medicines once a week and filled out checklists to confirm this. We checked medicines at random on the day and all medications were in date. All emergency medicines had security tags to prevent tampering.

Medical gases including oxygen and liquid nitrogen were stored correctly. The hospital had an oxygen pipeline system in areas where staff conducted minor clinical procedures. Managers provided staff with added training on liquid nitrogen management and medical gas training formed part of staff's mandatory training.

Consultants could prescribe medicines during clinics, and these were either electronically sent to the pharmacy for collection or a paper-based prescription was written. A record of any medication prescribed was put in the patient's notes and managers had arrangements for the tracking and safe storage of blank prescriptions.

Good

Outpatients

Pharmacy arrangements ensured the safe storage of medicines. This included suitable security precautions for the locking of controlled drugs. The department had oversight of pharmacy staff responsible for medication. This included the processing of any controlled drug requests. The department did not have any medicines that required fridge storage.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately.

Staff knew what incidents to report and how to report them. Staff had access to an incident reporting system. Staff we spoke with showed an understanding of incidents or events that would require reporting. A clear policy and pathway guided staff on how to report incidents. There had been no serious incidents reported in the past twelve months. Nine incidents had been reported between November 2021 and January 2022 for the department. Managers had reviewed all incidents and identified actions and learning lessons.

Staff understood the duty of candour. Managers gave one example where duty of candour was required following the correct process and evidence associated with this was provided. Managers spoke about being open and honest with patients, apologising if something went wrong and learning lessons through the process.

Managers had systems to ensure staff knew about safety alerts and incidents. Staff interviewed understood the concept and where to look for safety alert updates. Managers had a system that included distribution and acknowledgement of receipt from staff.

Are Outpatients effective?

Inspected but not rated

At present we do not rate effectiveness for outpatient departments in acute independent hospitals but during our inspection we noted the following.

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. New guidance was covered during monthly clinical governance meetings and emails would be sent to departments to review guidance relevant to their department.

For wider hospital policy, please see the surgery core report.

Nutrition and hydration

The department had coffee and water stations available for patients who required it. For wider hospital policy, please see our surgery core report.

Pain relief

Staff monitored patients to see if they were in pain.

Consultants managed pain relief while running their clinic. Managers and staff had access to pain medication if this was needed through a pharmacy in the hospital where the pharmacy team managed all medication associated with the department.

Patients were routinely assessed for pain in the department, but it was not a clinical risk typically encountered in some clinics delivered. However, if needed, pain would be discussed by the consultant as part of the presenting condition and captured in the patient notes. Blank prescriptions were also available for consultants to use.

Consultants and staff assessed pain during minor operations conducted at the department and there was medication available to support this.

For wider hospital policy on pain management, please see our surgery core report.

Patient outcomes

Staff checked the effectiveness of care and treatment where possible.

Managers completed patient outcome audits at the hospital site, however data for the outpatient department performance was limited. Staff explained a recent piece of work involved the correct coding process for data streams associated with orthopaedic operations and their outcomes. This fed into a wider audit structure conducted by the hospital.

Please see the surgery core report for more details.

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. The provider checked professional memberships required for staff to carry out their roles. Healthcare assistants completed an external care certificate for their professional development.

Managers gave all staff a full induction tailored to their role before they started work. Two separate induction packs were produced for nurses and healthcare assistants and new staff were given a mentor to support them when they first joined the team. Managers had created a folder for new staff that outlined all consultants working at the hospital including how rooms should be setup for certain clinics and staff said they found it helpful. A new member of staff we spoke with expressed how welcoming and helpful the team had been. Managers also arranged for more training where needed. For example, training on negative pressure wound therapy and intermittent catheterisation courses were arranged when a need was found.

Managers supported staff and ensured they had yearly appraisals of their work. We reviewed three appraisals after the inspection. Managers discussed staff development during appraisals and included extending staff skills to different clinical areas, for example a staff member had developed from a non-clinical role to a clinical role through conversations with managers.

Managers and staff said that face to face meetings were disrupted at the department. Managers had conducted three meetings in 2021. However, the hospital more widely had other mechanisms to communicate with the department.

Good

Outpatients

Senior managers conducted wider virtual meetings as an alternative and minutes of these meetings were available on the hospital computer system to review. This included information that was specific to the department. This reassured us that important information was communicated to the team. Staff interviewed also said that they were happy with the current arrangements for the department.

Multidisciplinary working

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

Staff were seen working well together. They described a positive working environment where they felt respected and were able to raise concerns with their colleagues and managers if they needed to.

Managers were present at head of department meetings and the daily communications call each morning which optimised communication channels between departments.

Wider multi-disciplinary team (MDT) working in the department was focused on Oncology services and regular meetings were attended with the aligned NHS trust to support service delivery.

For further information, please see the surgery core report.

Seven-day services

Key services were available six days a week to support prompt patient care. Wider hospital services were available seven days a week.

The provider operated clinics six days a week. Consultants ran their clinics at different times in the morning, afternoon and evening on weekdays and managers arranged this ahead of time with the consultants. Outpatient clinics did not run on Sundays but were operational on Saturday morning and afternoon. The wider hospital remained open for patient enquires and inpatient services.

Health promotion

The department had relevant information available promoting healthy lifestyles and support in clinics. Managers removed information leaflets from the department in line with COVID 19 guidance. The information was available if requested by patients and followed the hospital accessible information standards (AIS).

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We saw evidence that consent for surgical processes was discussed during appointments where a surgical procedure was proposed. Staff gave patients time to have a thorough discussion with their consultant and time to think about their treatment options.

Where written consent was needed for some minor operations conducted at the department, for example, skin procedures. We reviewed five consent records to ensure staff fully completed this. Arrangements to support communication needs of patients when indicating their consent including interpretation services. Staff could arrange this with the hospital booking team ahead of time.

Good

Outpatients

Staff could describe and knew how to access the policy on the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLs). Staff we interviewed could explain where policies were found for reference if they required this. Safeguarding training had content associated with MCA and DoLS so staff were trained to a suitable standard. Staff were also trained in dementia so that they could support patients in the consent process.

Staff did not have examples associated with complex consent but a policy was available which took into account the requirements of the MCA (2005).

Patients were entitled to a cooling off period before any elective cosmetic surgery was conducted.

Are Outpatients caring?

Good

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

Compassionate care

Staff treated patients with compassion and kindness. Staff always respected their privacy and dignity but did take account of their individual needs.

Patients gave positive feedback about the service. Comments Included:

“Fantastic care, making sure I fully understood what was happening”

“Informative, supportive and progressive response to my injury delivered in an extremely professional manner”.

“Very Helpful and Polite”

The results and analysis from the postcard scheme run at the hospital following our inspection were that between December 2020 and December 2021, positive feedback accounted for 99% of responses.

Patients and their families could give feedback on the service and their treatment. When needed, staff supported them to do this. Feedback postcards were the main source of feedback at the department. Managers clearly displayed the cards for patients and signs were available in the main corridor promoting the scheme.

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 took time to interact with patients and those close to them in a respectful and considerate way. Staff cared for patients and were attentive to their needs during interactions. For example, we saw staff opening doors and providing help for patients.

Good

Outpatients

Staff supported patients and helped them keep their privacy and dignity. The department had a quiet area for privacy and consultation rooms had areas where patients could change in private and locks on the doors. Where patients had cultural and religious needs, staff were flexible in accommodating their needs. This included chaperone arrangements which were available if examinations were required and all aspects of treatment were explained with respect given if patients were unhappy with a particular approach.

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 showed how they helped patients as part of their role. Feedback for the department following the inspection proved that staff were attentive and explained processes to their patients. For example, where a procedure was proposed, staff were praised as being clear, kind and considerate to patient needs.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Managers positioned patient feedback postcards where they were visible through advertising and staff were proactive in directing patients to this.

Patients gave positive feedback about the service. Patient survey data for the department was on 99% positive in 2021.

Are Outpatients responsive?

Good

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

Service delivery to meet the needs of local people

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 showed how they helped patients as part of their role. Several examples of feedback we reviewed praised staff on their engagement with patients during an appointment and their clear manner in explaining decisions for treatment. Patients described feeling empowered to make their own choices and that there was flexibility associated with this.

Patients gave positive feedback about the service. Patient survey data for the outpatient department was on average 99% positive in 2021.

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.

Good

Outpatients

Patient's individual needs were reviewed during the booking of an appointment. Staff used the information to provide care and treatment in a safe way and eliminate possible risks for the patient. Where staff found that the service could not meet the patient's needs, staff would not treat them at the hospital, but refer them to an alternative health care provider who could better support the patient.

Staff working in the department knew in advance which patients were attending clinics that day. Staff highlighted patients on the clinic list of attendance that requiring extra help or support and measures were organised to support them.

The department had suitable signs to let patients know hearing loops were available in the hospital. Staff provided patients with information on the facilities provided at the hospital. The information met the accessible information standard (AIS) and included information leaflets on demand in a wide variety of languages and font sizes for patients to ask.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Staff booking an appointment added translation needs on the booking system so that arrangements could be made ahead of time.

Access and flow

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

Managers and staff worked to make sure patients did not spend longer than they needed to in the department. The department arranged for tests to be conducted at the same time as their appointment to reduce unnecessary visits. For example, if a scan was scheduled, efforts would be made for a patient to be seen in the clinic the same day, where possible.

There wasn't a waiting list for appointments in the department. Patients are made aware of clinic availability for their chosen consultant and are able to choose the available appointment time to suit them. If an appointment was cancelled or a patient was unable to attend, a phone call was made promptly to rearrange the appointment. Staff triaged the calls according to clinical risk. For example: a post operation consultation would be a priority. Staff showed the booking process to us on the day, included how the referral was received and processed before making the booking to an available clinic.

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 learnt with all staff. The service included patients in the investigation of their complaint.

The department received 16 complaints between February 2021 to January 2022. The highest number of complaints received in one month was three.

Managers investigated complaints and found themes. Managers raised new complaints with senior managers during a daily communications call. This ensured senior managers had a recording of the complaint as early as possible.

For wider details of the hospital complaint process please see the Surgery core report.

Good

Outpatients

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints and positive feedback were a standing agenda item for department team meetings.

We did not speak to patients directly regarding their ability to make complaints, but we saw leaflets in the department that explained the complaints process for patients.

Where the department needed to, a duty of candour was met. We saw an example of this from the last twelve months where managers were transparent and open in their findings and future actions associated with the incident, this included a letter to the patient affected.

Are Outpatients well-led?

Good

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

Leadership

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

There were clear lines of leadership and accountability. Line management was divided between clinical and non-clinical staff with separately named line managers. Managers had a good understanding of the challenges to quality and sustainability in the department and were able to tell us the actions needed to address them. They told us they felt supported by other members of the senior management team. They were able to discuss any issues with them, felt listened to and had their views respected.

Managers supported staff to undertake training to develop their skills. Managers discussed career development of staff at their appraisals. Staff from the department said they felt managers provided opportunities to develop.

Staff working in the department spoke highly about their managers and felt supported and valued. Managers were highly visible and approachable, and we saw evidence of this on the inspection including individual attention to staff development and the needs for specialised training and induction processes in the department.

Please see surgery core service for wider details.

Vision and strategy

The vision and strategy are focused on sustainability of services and is aligned to local health plans.

Staff understood the providers values and the direction the organisation intended to develop. A newsletter produced by the hospital allowed staff from the department to keep up to date with developments in the hospital.

Please see surgery core service for wider details.

Good

Outpatients

Culture

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

Managers promoted equality and diversity. Staff spoke of a friendly, inclusive environment which included international nurses from different cultures. All staff from the department completed equality and diversity training.

Staff said they felt comfortable raising concerns with their line manager. Staff expressed having a good relationship with their manager.

Please see surgery core service for wider details.

Governance

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

The department had limited meetings to give information to staff directly in the last twelve months. However, recent meetings had been conducted at the department and managers utilised the daily communication call for the hospital with emails to inform staff of important operational changes. We reviewed minutes from three department meetings and daily communication call minutes where information was discussed, shared and acted upon to improve patient safety, care and outcomes. Staff could raise operational concerns both at meetings and privately with their line manager who would then escalate this to the daily communication call for the hospital.

Please see surgery core service for wider details.

Managing risks, issues and performance

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

The department had a risk register which was checked at department level and by senior management who operated a wider hospital risk register. The main risk in the department risk register was the need to increase registered staff, however the department had measures in place to manage this and staff did not raise concerns to us regarding staffing levels in the department.

Please see surgery core service for wider details.

Managing information

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

Staff did not leave computers unattended and areas holding information were locked when left unattended.

Staff received mandatory training for information governance. The department training completion rate was 100% Staff observed were mindful of confidential information held by the department and took steps to ensure this information was secure.

Good

Outpatients

Please see surgery core service for wider details.

Engagement

Leaders and staff actively and openly engaged with patients and staff.

The department actively encouraged patients to give feedback about their experience to help improve services. For example, through patient feedback cards, and promoting reviews on search engine websites.

Managers of the outpatient department understood the importance of staff feedback. The outpatients' staff were happy in their roles and felt listened to. A staff survey was in operation to enhance worker morale and opinion. The results suggested that improvements in staff morale were happening.

Please see surgery core service for wider details.

Learning, continuous improvement and innovation

The department prioritised learning and improvement among their staff. Staff we spoke with wanted to develop the service and themselves to give the best experience for patients. For example, one staff member was trained in a specialised wound therapy technique to optimise the healing of a patient's post-operative wound.

The department were innovative with their induction processes. The induction packs were specific to clinical and non-clinical roles in the department. Managers enhanced induction packs further by customising them to individual clinical job roles. Staff valued this level of detail and expressed it supported them.

The department have also introduced a pathology tracker allowing them to track specimens and results in further detail.

Wider improvement and innovation initiatives are covered in the surgery core service report.