Ramsay Health Care UK Operations Limited

Beacon Park Hospital

Inspection report

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

Ratings

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of the services on 3 August and 28 September 2022, we completed a further follow up inspection on 21 February 2023.

Beacon Park Hospital opened in May 2020, the hospital is managed by Ramsay Health Care UK Operations Ltd and is part of a network of over 34 hospitals across England. In addition, they run hospitals in Australia, Indonesia and France and Scandinavia.

As this was the first inspection of this hospital, we inspected 4 core services: surgery, medical care, outpatients and diagnostic imaging and screening. The same senior management team supported both this hospital and Ramsay Rowley Hall Hospital. The overarching governance and reporting systems worked in conjunction. Many staff worked across both hospitals.

At the time of inspection, the hospital director was the CQC registered manager and had been in post since August 2019. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The hospital is registered to provide the following regulated activities:

• Diagnostic and screening procedures

• Family planning

• Surgical procedures

• Treatment of disease, disorder or injury

Following this inspection our overall rating of this service was good. We rated it as good because:

- The service had enough staff to care for patients and keep them safe at the time of the inspection. 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 7 days a week.
- Staff treated patients with great compassion and kindness, fully respected their privacy and dignity, took account of their individual needs in a person centred, holistic way, and helped them understand their conditions. They provided emotional support to patients, families and carers. Feedback from patients was exceptional.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

Summary of findings

- Experienced and compassionate leaders ran services very effectively using reliable information systems and supported staff to develop their skills. Staff fully understood the service's vision and values, and how to apply them in their work. Staff felt respected, fully supported and valued. They were fully focused on the needs of patients receiving care and took pride in their work. Staff were very 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:

- There were gaps in cleaning documentation for the C-arm X-Ray machine and lead personal protective equipment.
- There were gaps in daily checks documentation for the C-arm X-Ray machine.
- We did not see evidence that quality assurance testing was carried out on the C-arm X-Ray machine monthly.
- One oxygen cylinder was not secure in the recovery area. This was resolved on the day of our inspection.
- A portal appliance label of check was not displayed on 1 piece of equipment. This was resolved on the day of our inspection.
- Not all records were securely. A theatre list was left in recovery which contained patient information.
- During our inspection we noted that the door to the area designated for the collection clinical waste was open with the padlock not locked.
- Several storerooms were not locked this included the intravenous medication store cupboard, the specimen room and the cleaning cupboard.
- The service provided drinks for patients, but no food was available.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care (Including older people's care)	Good 	This was our first inspection of this service. 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 a drink and biscuits following an endoscopy procedure 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 during opening hours. • 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. • Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported, and valued. However: • One oxygen cylinder was not secure in the recovery area. This was resolved on the day of our inspection.

Summary of findings

- A portal appliance label of check was not displayed on 1 piece of equipment. This was resolved on the day of our inspection.
- Not all records were securely. A theatre list was left in recovery which contained patient information.

Diagnostic imaging

Good

The service has not been previously rated. We rated it as good because:

- Staff generally received and kept up-to-date with their mandatory training, including safeguarding training.
- The service had clear systems in place to ensure that risks were assessed and appropriately managed.
- The service had enough staff with the right qualifications, skills, training and experience to provide the right care and treatment to patients.
- The service monitored the effectiveness of care and treatment through a series of local audits.
- Staff treated patients with compassion and kindness and respected their privacy and dignity.
- Facilities and premises were appropriate for the services being delivered.
- Leaders had the skills and abilities to run the service, were visible and approachable in the service. They supported staff to develop their skills and take on more senior roles.
- Staff felt respected, supported and valued**.**
- Leaders operated effective governance processes, staff were clear about their roles and had regular opportunities to meet, discuss and learn from the performance of the service.

However:

- There were gaps in cleaning documentation for the C-arm X-Ray machine and lead personal protective equipment.
- There were gaps in daily checks documentation for the C-arm X-Ray machine.
- We did not see evidence that quality assurance testing was carried out on the C-arm X-Ray machine monthly.

Surgery

Good

This was the first inspection of this service. We rated it as good because:

Summary of findings

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

Outpatients

Good

This was our first inspection of this service. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety

Summary of findings

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 to patients 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.
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Summary of findings

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Background to Beacon Park Hospital

Background

Beacon Park Hospital opened in May 2020 and is 1 of 34 centres across the UK where Ramsay Health Care UK Operations Limited is working in partnership with the NHS. Beacon Park Hospital has day case facilities including 1 theatre combined with endoscopy, 6-day case pods with sliding doors, outpatient/pre-assessment rooms and a treatment room. The day unit is developed for the assessment, diagnosis and treatment of conditions on a day case basis for both NHS and private patients locally. The hospital does not treat children under the age of 18 years old.

Beacon Park Hospital adds the following additional facilities to those which are already in place at Rowley Hall Hospital (3 miles away) with:

- 1 theatre with 2 recovery bays.
- Ambulatory Unit with 6 pods, gender specific areas.
- C-Arm X-ray for guided procedures.
- 3 outpatient consulting rooms with 1 being used as an ophthalmology room.
- 1 treatment room.
- Appropriate waiting area – admissions lounge.
- Up to 80 parking bays.
- Access to a mobile MRI pad.
- Access to a mobile CT scanner.

Surgical procedures included ambulatory and day surgery only, gastroenterology, general surgery (including laparoscopic inguinal hernia repair), ophthalmic orthopaedics, colorectal endoscopy, ophthalmology (included laser), podiatric surgery, urology and ear, nose and throat procedures.

The day surgery facility provides services for private, insured and NHS patients within the local community and further afield. The new facility includes a theatre and recovery area, 6 day-patient pods, 3 outpatient consulting rooms, 2 pre-assessment rooms and a minor treatment room offering treatment for pain management, urology, endoscopy and ophthalmology (eye care).

There is a contract with a local NHS trust. The provider has moved over all local anaesthetic treatments to Beacon Park Hospital and they were undertaking endoscopy, cataract operations, pain management and foot and ankle local anaesthetic work

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

Summary of this inspection

How we carried out this inspection

We visited the service on 31 August, 28 September 2022 and 21 February 2023. The inspection team Included a CQC inspection manager, 5 inspectors and 4 specialist advisors with extensive nursing experience, expertise in endoscopy and expertise in theatres. Throughout the inspection, we took account of what people told us, and how the provider understood and complied with the Mental Capacity Act 2005. The inspection was overseen by Charlotte Rudge, Interim Deputy Director of Operations.

As this was the first inspection of this hospital, we inspected 4 core services: surgery, medical care, outpatients and diagnostic imaging and screening. The same senior management team supported both this hospital and Rowley Hall Hospital. The overarching governance and reporting systems worked in conjunction. Many staff worked across both hospitals.

We spoke with 41 staff, 22 patients and relatives, and reviewed the records and associated documents for 14 patients. We met with the hospital's leadership team on site and in a virtual meeting. Following the inspection we spoke with 4 patients over the telephone and reviewed 8 staff files, reviewed documents including but not limited to: training documentation, staff appraisals, policy documents and a variety of governance information.

We used our unannounced comprehensive inspection methodology. 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:

Leadership and culture reflected a clearly compassionate and caring service, fully focused on holistic person-centred patient care. This was reflected in the feedback received from patients.

Areas for improvement

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

Action the service SHOULD take to improve:

- The service should ensure it monitors waiting lists due to the number of patients waiting over 52 weeks for treatment. (Regulation 12).
- The service should ensure that cleaning of equipment including the C-Arm X-Ray machine and lead personal protective equipment is always carried out after use and documented (Regulation 12).
- The service should ensure that daily checks of the C-Arm X-Ray machine are carried out and documented (Regulation 12).
- The service should ensure that quality assurance is carried out on the C-Arm X-Ray machine and documented as per service guidelines (Regulation 12).
- The service should ensure oxygen cylinders are secured safely (Regulation 12(2)(e))

Summary of this inspection

- The service should ensure records containing confidential information are securely kept. (Regulation 17(2)(d))
- The service should consider portable appliance testing labels are displayed on equipment before use. (Regulation 15(1)(e))
- The service should ensure that all doors and areas that should not be accessible to the public are always locked. (Regulation 15)
- The service should consider the provision of food for patients who may be onsite for treatment and need nutrition during the day. (Regulation 14)
- The service should ensure that staff completion for performance development reviews is up to date. (Regulation 18)

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Medical care (Including older people's care)

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

Is the service safe?

Good

This was the first inspection of the service. We rated it as good because:

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

Staff at all levels kept up to date with their mandatory training and overall compliance for mandatory training improved and was 91%, this included modules, such as basic life support, advanced life support and safeguarding. Staff completed additional e- learning training modules and overall compliance exceeded 96%.

Staff told us they were able to access training through a learning academy on the internet which identified any new training for them to complete. We saw a staff member completing their training on day of the inspection. Staff told us it was important to complete training and the academy sent reminders when training was due to be completed.

The mandatory training was comprehensive and met the needs of patients and staff. All staff had completed comprehensive induction and training modules, the areas included fire and safety, basic life support, infection control, Mental Capacity, health and safety, safeguarding and consent.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia. The service had named dementia lead for support and advice. The staff completed online training to support patients with dementia, a learning disability and autism. The service promoted autism awareness. Staff knew how to respond to patients with a learning disability or patients living with dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff were sent a reminder email when training was due and a completion target date. Training was also a key part of governance meetings; staff were reminded consistently to complete training by managers.

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.

Good

Medical care (Including older people's care)

All staff received training specific for their role on how to recognise and report abuse. All staff received training staff were able to give examples of reporting abuse a patient. Overall compliance improved for safeguarding training for the service was 92 % for adults' safeguarding level 2 and safeguarding children level 1, 2 and 3 was 93%. A staff member told us if a patient shared, for example, that a member of their family abused them they would report this as a concern immediately.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff were able to give examples of how to protect patients from abuse. Staff told us they had access to a safeguarding lead within the service and leadership for support. The service displayed easy access flowcharts for staff to refer to if they had any concerns that a patient was at risk of abuse. Senior leaders were knowledgeable about how to access external services if concerns were raised or identified with patients and their families, by contacting the local authority.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The hospital did not treat children under the age of eighteen, but staff had completed child safeguarding training and knew how to report and identify children at risk of abuse.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could demonstrate they knew how to make a safeguarding referral if they had any concerns.

Leaders recruited staff safely within departments, this included an enhanced Disclosure and Barring Service certificate, history of employment and references, followed by a comprehensive induction and training.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. We saw hand hygiene audits which were completed and scored 95%. We saw the recovery suites, pods and waiting area specific for to endoscopy patients which were exceptionally clean. Housekeeping staff cleaned areas after use. The housekeeping team monitored the cleaning schedules within the department, this included pods and regular touch points being cleaned. The cleaning schedules were in place and overseen by the operations manager and maintained consistency in the month of July and August 2022. The staff understood the importance of high standard of cleaning and prevention of infection. Overall environmental audit was 100% and improved since March 2022.

The endoscopy suite had separated clean and dirty facilities to maintain infection prevention and control. The service carried out regular audits of equipment, endoscopy, and decontamination.

The service generally performed well for cleanliness. The service completed audits to maintain cleanliness. Audits were completed and actions were discussed during team meetings. The staff were able to explain the importance of cleaning to maintain standards of the service. We viewed audits and the service performed well, for example, 100% in June 2022, areas had significantly improvement with ongoing actions since March 2022.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The housekeeping staff cleaned all areas and signed off when areas were cleaned, within a timely fashion. Staff told us this was important to maintain a clean hospital to prevent infections.

Good

Medical care (Including older people's care)

Staff followed infection control principles including the use of personal protective equipment. We saw staff wearing personal protective equipment within the hospital. There was enough masks and sanitising units in each area. Reminder posters for hand hygiene were displayed near sinks and within clinical areas of the hospital. Notices as the service entrances reminded patients to wear a mask and to sanitize their hands before entering. We observed staff were bare below the elbow to prevent infections.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Green tags were attached to equipment with the date recorded of when it had been cleaned. We observed equipment being cleaned during inspection.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. We saw the patient were able to access the call bells in areas and staff were visible if support was required. Staff assisted patients when they asked or called for help. For example, we saw a nurse and health care assistant walking with the patient to their procedure as the patient required assistance.

The design of the environment followed national guidance. The service was designed following the national guidance and spacious for patients with reduced mobility or access for wheelchair users. Changing facilities were suitable for all to use. Pods were equipped with cleaning facility, this included sinks and handwashing dispensers. The endoscopy suite had separate changing facilities for male and female patients.

Staff carried out daily safety checks of specialist equipment. Checks of equipment were regularly audited and monitored We checked equipment in the recovery area where endoscopy patients were seen in the recovery, weekly and monthly checks of equipment this included a critical care transfer bag. However, we noticed 1 oxygen cylinder was not secured and a piece of equipment designed to give medicine did not have a portal appliance label. We raised this with the head of clinical services who resolved both concerns during our visit.

The service had enough suitable equipment to help them to safely care for patients. The service had enough suitable equipment, this included emergency equipment this was this was checked daily and signed for. The staff could quickly access resuscitation trolley centrally kept, with an allocated resuscitation team.

All scopes with endoscopy were single use.

Staff disposed of clinical waste safely. An external service collected all clinical waste. All waste was collected from a door at the back the building. All clinical waste bins within the area were secure and locked and waste was managed safely. Sharps bins were dated and labelled correctly.

The service managed cleaning products were stored safely in line with Control of Substances Hazardous to Health Regulation 2002. The doors to the cleaning cupboards were locked so cleaning products could not be accessed by an unauthorised person.

Assessing and responding to patient risk

Good

Medical care (Including older people's care)

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 monitored observations for patients such as blood pressure, pulse and oxygen levels. Staff understood the track and trigger the National Early Warning Score chart and recognised patients when they deteriorated. Staff were able to access a chart within clinical areas for scoring. If patients deteriorated and required transfer clinical staff would call for an ambulance. Staff continued to assess the patient during day care until transfer to their local trust if there was an emergency.

The service had a good relationship with trust and would communicate the transfer over telephone of the concerns and share discharge summaries. Staff told us “Patient care comes first” Staff had access to a registered medical officer and a consultant to deal with patients whose condition was deteriorating, in an emergency the staff would call 999 for any patients who required urgent care.

The service had access to sepsis box and resuscitation trolley, this was checked daily.

Staff completed risk assessments for each patient on admission on arrival, using a recognised tool, and reviewed this regularly, including after any incident. The staff understood risks to keep patients safe. Patient records were completed in detail before a procedure, this included specific risks assessment for moving and handling and allergies of the patient.

Staff knew about and dealt with any specific risk issues. Patients were assessed for falls and pressure care; risks were identified during a pre-screening of procedure. The service had access to a sepsis box if there were signs of deterioration and a resuscitation team was and available.

The service had access to mental health liaison and specialist mental health support during opening hours. If patients required additional support, they were able to seek support from a dementia lead or a mental health coach. Staff were able access other services if support was required.

Staff shared key information to keep patients safe when handing over their care to others. Discharge summaries were sent to the GP in detail including outcomes and any concerns, following procedures in endoscopy. This was carried out by the ward clerk. Patients told us feedback was given by staff following their procedures and discharged back to the community.

Shift changing included all necessary key information to keep patients safe. The team met daily through huddles and monthly meetings.

Staffing

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

The staffing within endoscopy consisted of 1 healthcare assistants and 2 registered nurses. The service has recruited an interim endoscopy lead. The service managed patients safely and worked with planned referrals, a small number of patients were seen weekly. Staff were able to work within endoscopy deployed from other departments and were trained

and competent. The endoscopy department worked with a pool of bank staff to support sickness, absences, and annual leave. Staff completed competency assessments prior working in the area. The staff were trained to provide care for patients safely. The service managed risk and ensured staffing levels were safe and staff were fully trained to ensure patient safety.

The service offered practicing privileges to consultants subject to a range of checks being completed. 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.

The service had enough nursing and support staff to keep patients safe. The endoscopy services were maintained safely with 1 healthcare assistant and 2 nursing staff. Some nursing staff and management were able to work across departments. Patients told us they felt safe with staff during their procedure.

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. Staffing numbers across all areas were safe to meet the numbers of patients visiting for an endoscopy procedure. The staffing levels were displayed centrally. A nurse told us if some appointments were referred in short notice, the team were flexible to meet the needs of patients.

Managers could adjust staffing levels daily according to the needs of patients. The service was able to deploy staffing levels to the needs of patients.

The number of nurses and healthcare assistants matched the planned numbers. The service managed with safe numbers of staffing and were able to deploy staff with right skills to meet patient needs. This included registered nurses, healthcare assistants and registered medical officer. The service was overseen by a ward manager 2 to 3 times a week. The service was able to manage planned numbers of endoscopy procedures and adapt the staffing. The service cancelled appointments due high levels of sickness during the pandemic and rebooked as soon as they could.

The service had low and or reducing vacancy rates and turnover. The staff retention was stable and low numbers of vacancies. The leadership were passionate about recruiting the right person for specific roles to develop the service.

The service had low reduced turnover rates. The service retained staff and encouraged development within the service.

The service had low or reducing sickness rates. The levels had increased sicknesses during COVID-19 pandemic, the service cancelled appointment's due high level of sickness in endoscopy.

The service had low and appointed bank staff to support the service. The service was able to deploy trained staff from other departments.

The service had enough medical staff to keep patients safe. The registered medical officer was on duty during planned endoscopy lists. Registered medical officer worked and across theatre and endoscopy to support the hospital.

The medical staff matched the planned number. The service always had a designated medical staff on duty for safety.

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.

Good

Medical care (Including older people's care)

Patient notes were comprehensive, and all staff could access them easily. The service used an electronic system for patient records. Staff had a separate login to access records. The records were comprehensive. We viewed 4 patient records and records included consents, risk assessments, discharge summaries, any medication and past medical conditions.

When patients transferred to a new team, there were no delays in staff accessing their records. The ward clerk told us the patient discharge summary was sent off to the GP the same day or the next day. We saw this on the service electronic system. This included a detailed report of the patient's journey following a procedure. Patients told us reports were shared with them.

Records were stored securely, and all staff were able to access records with login. Staff signed out when moved away from their computer. During the inspection we noticed a theatre list was left in recovery, this was removed at time, following feedback with the staff.

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. Patients told us before a procedure they were offered sedation and were involved in their decisions. Staff followed safe management of medication in line guidance and their internal policies.

Controlled drugs were checked once a day and signed.

Staff reviewed each patient's medicines before an endoscopy procedure took place. We viewed medication administration records which were stored on an electronic system. Patient medication was checked during pre-assessment of any procedure, this included conditions or any allergies.

Staff completed medicines records accurately and kept them up to date. We viewed this on the electronic system and no gaps were identified.

Staff stored and managed all medicines and prescribing documents safely. Medicines cupboards were safely secured, and daily checks were carried out and recorded. The pharmacy team audited the medication cupboards and actions were taken to improve. Emergency medication was stored and sealed for safety.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. The service transferred patients in an emergency and completed discharge summaries following procedures which included information about any medication.

Staff learned from safety alerts and incidents to improve practice. This was actively shared during clinical meeting and learning had taken place to improve with clinical staff.

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.

All staff knew what incidents to report and how to report them. Staff complied with policies and processes of the service. They knew how to report an incident by following their own corporate policy using an electronic system. The local policy included guidance on how to maintain quality and consistency when patients were involved in an incident. Staff knew how to explain to patients in a sensitive manor when mistakes were made. Staff understood the importance of duty of candour and completed a checklist following feedback to the patient.

Staff raised concerns and reported incidents and near misses in line with provider policy. Managers investigated incidents fully with a detailed response. Managers and staff understood duty of candour when things went wrong. We viewed a letter to a patient following a colonoscopy procedure which contained an apology related to a previous incident. It had been investigated and shared with staff for learning. All staff were able to raise a concern. Staff understood the importance of learning from incidents and near misses and shared practices within service and the wider organisation. The service embedded a being open policy meeting with relatives or patients when an incident had harmed a patient.

The service no never events and 2 serious incidents

We reviewed governance meetings minutes for July 2022. Meetings were held with all senior leaders and discussed areas which could improve such as training, a reminder of General Data Protection Regulation, reviewed risk register, and actions to complete from a recent commissioning visit. The service learned from incidents during these meetings. The service shared CQC weekly bulletins, these were sent out to all staff by email.

Managers shared learning with their staff about never events that happened elsewhere. Leaders held governance monthly meetings, to discuss any learning and improvements that could be made. Learning and concerns were shared across all departments and reflected in action plans and the wider organisation.

Staff reported serious incidents clearly and in line with policies and procedures, Staff told us they would report incidents through their electronic system and make managers aware.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. The staff were able to explain duty of candour and understood when things went wrong. They fedback verbally within 24 hours to the patients and explained with sensitivity. Staff and leader's understood learning from mistakes internally and from other services within the organisation. We saw a detailed explanation of recent when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. The service shared information through there huddles team meetings following any investigations and incidents. This was important to the service to learn and share. The staff told us it good when get feedback as we would like to improve.

There was evidence that changes had been made as a result of feedback. The service made changes when areas required to improve, by sharing learning through clinical governance meetings and safety huddles. Leaders told us they discussed feedback during staff one to ones. Feedback was discussed at daily huddles, governance meetings and this included positive compliments.

Good

Medical care (Including older people's care)

Is the service effective?

Good

This was the first inspection of the service. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. 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. Staff we spoke to were knowledgeable of internal and external policies during inspection. Information and new policies were discussed and shared at daily huddles and emailed to all staff to implement.

Staff and managers protected the rights of patients. The service displayed a strategy at provider level with the service to protect vulnerable adults. The staff were aware of the human rights law and to safeguard patients when it was required. The service followed their own policy when looking after patients living with dementia and or learning disability to utilise and knowledgeable.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Staff made sure patients were offered drink and biscuits.

Patients were able to access water from cooler in waiting areas if they required a drink following a procedure.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice

We viewed patient medicine charts as a part of pre-screening, pain relief was reviewed as part of pre-screening prior to a procedure.

Patient outcomes

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

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

Good

Medical care (Including older people's care)

The service had a lower rate of patients being referred to the hospital in an emergency, this was rare occurrence, the staff were trained and knew what to do.

Managers and staff used the results to improve patients' outcomes. The service involved patient participation services, this is so staff and the service could improve. The service actively shared with staff to improve and be recognised when things went well.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service completed audits infection control, hand hygiene, environmental audit to improve and discussed apart of clinical meetings. This included monitoring infection rates, environmental audits, and medicines. Audits were scored green when action were completed on time or red with a time action date.

Managers used information from the audits to improve care and treatment. Leaders shared audits through governance meetings.

The leadership team recruited a new endoscopy lead for the service, this was a plan to work towards and achieve Joint Advisory Group on gastrointestinal endoscopy accreditation.

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 service was supported by a national endoscopy lead to induct and support the new lead. The service was able to deploy staff across departments to meet the needs of patients. For example, a deputy theatre manager told us she had recently worked in endoscopy and was trained to do so.

Managers gave all new staff a full induction tailored to their role before they started work. Staff received a comprehensive endoscopy and orientation induction. New staff were inducted and supported by their colleagues with shadow shifts. The induction covered areas like, medication administration, early warning scores, use of medical devices and clerical processes in endoscopy. All staff working within endoscopy were assessed with a detailed induction and followed up through appraisals over a 12-month course. We viewed the matrix for completion dates of training for equipment use with endoscopy, such as a rapid air washer, flexible endoscopy technical repair and probe training. The leadership team monitored this to maintain consistency and safety of competency before procedures were carried out to keep patients safe.

Managers supported staff to develop through yearly, constructive appraisals of their work. The staff told us they had a yearly appraisal, which was confirmed by management records. During their appraisals staff were encouraged to develop through training and job roles. The staff told us the leadership always promoted growth of the staff by encouraging them to attend courses, and take on new roles, and responsibilities.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. The service held clinical meetings, this was an opportunity for clinical staff to develop and share any good practice and learning within the service to drive improvement. Clinical supervisions were completed during staff one to ones. Leaders encouraged development and shared any learning and positive feedback.

Good

Medical care (Including older people's care)

The clinical educators supported the learning and development needs of staff. The endoscopy competency was detailed, and staff were equipped within the endoscopy area to provide care. The national endoscopy lead supported and shared knowledge and expertise with service achieve the best outcome.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Team meetings were shared across the staff teams and shared across departmental meetings by email. Staff told they could go back and read if they were on sick or annual leave. Leaders encouraged staff to attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The service recently invested in a transfer aid and the staff were trained to use this.

Managers identified poor staff performance promptly and supported staff to improve. Managers discussed this through one to ones and internal meetings. Managers supported staff to set objectives with support to improve. Staff were provided support through employee assistance and mental health coach if required.

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. The service held daily huddles with all departments across with their sister hospital site. The staff told this helped them learn from others, Including patient feedback, complaints, compliments, and rota management. A staff member told us we learned from a recent CQC inspection which had taken place at another site within the organisation. The staff informed us meetings were informative, and valuable for everyone and kept the team up to date during absence and annual leave.

Staff worked across health care disciplines and with other agencies when required to care for patients. The staff told us they worked in the theatre and were able to work in endoscopy when there was need.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. The service completed pre assessments for patient's prior endoscopy procedures, this prepared staff to support patients with mental health needs and the service had access to a mental health coach.

Patients had their care pathway reviewed by relevant consultants before discharge and were referred to the GP within timely manner.

Seven-day services

The hospital was not open seven days a week and providing planned sessions through the week.

The hospital endoscopy services operated from 8am to 5pm Monday to Saturday. The procedures for endoscopy were scheduled, depending on referrals. Endoscopy services was a small proportion of the service and planned referrals varied. A small number of patients were referred from the NHS and some were private.

Consultants were available procedures, including weekends during opening times. Patients were reviewed by consultants depending on the care pathway. Staff told us a consultant would make joint clinical decision when patient deteriorated and transferred safely to the local trust or home.

Good

Medical care (Including older people's care)

Staff could call for support from doctors and other disciplines, including mental health services during opening hours and on call leadership. Staff were supported if they required advice.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support. We saw patients could access various leaflets in waiting areas. These included smoking, endoscopy, cataract procedures, diet etc. Staff told us if patients asked, we would find information and support them.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients were pre assessed before an endoscopy procedure, this included a screen of their health and wellbeing and any risks.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were knowledgeable about mental capacity and deprivation liberty safeguards. The staff would hold multi-disciplinary meetings to discuss plans in the patient's best interest. The staff sent out a 'this is me' document to patients for relatives to complete prior to an appointment, if a formal diagnosis of dementia was seen on patient records, this enabled staff to look after patients better by knowing their likes and dislikes.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We saw 4 signed consent forms had been completed on the electronic system before a procedure and patients understood what they came in for. Patients told us their gastroscopy throat spray was explained to them and they understood what they came in for.

When patients could not give consent, relatives supported patients. Staff worked in patients' best interest if patient was unable to make a decision for themselves.

Nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. All staff were trained and able to give examples of when they had worked in patients' best interest.

All staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. 91% of staff had completed training overall. Training was continuously improved, and managers encouraged staff to complete.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Good

Medical care (Including older people's care)

Is the service caring?

Good

Our rating of this service. 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. Patients reported they had no concerns during their procedures. Patients who visited the service for a procedure continually positive about the way staff treated them. Staff went an extra mile and with the care and support. Patients told us staff were excellent and explained the procedure with a very kind and caring an attitude. We observed a gastroscopy procedure; the staff explained the procedure with sensitivity going through all risks keeping the patient involved. During the procedure staff reassured the patient throughout the journey. Patients told, they felt safe, staff were compassionate and have made every little difference to me during my procedure. Patients were treated with privacy and dignity. Patients complimented the service and were happy with their procedures and care they received. We saw one patient complimented the staff during inspection following a procedure.

Patients said staff treated them well and with kindness. Patients shared positive feedback and completed written compliments during inspection. Patients complimented nurses on discharge from the hospital. Patients described staff as kind and very professional and “it made my visit so easy when I felt anxious.” Patient told us they were involved in decisions with their care. “We can’t fault them” they are fantastic.

Staff followed policy to keep patient care and treatment confidential. Staff knew how to keep confidential information safe. We observed during inspection documents were kept secure and computer screens were hidden.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff told us it was important to assess patients prior to procedures and would determine if patients required more support or care with specific needs during an endoscopy procedure.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. The staff were knowledgeable about the individual patient before a procedure as a pre assessment screen was completed. Staff understood specific needs of patients, such as cultural and personal during a pre assessment. Patients were able to contact the hospital prior their appointment if they required a specific need.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw a patient became very anxious during a procedure, the staff continued with care and reassured the patient.

Good

Medical care (Including older people's care)

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff always maintained dignity and respect and were discreet when patients became anxious or distressed, maintaining their privacy and providing reassurance.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. Staff told us patients can become anxious during a procedure and they provided reassurance to the patient to ensure they were comfortable. The staff we observed were caring and communicated very well.

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. Patient told us procedures were explained to them beforehand. Patents received a letter with leaflets to explain the endoscopy procedure. Patients had opportunity to speak to staff before the procedure to ask any questions if they were generally feeling anxious. Staff told us we care for patients, and we want the best for them.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. The service was able use a translation service if required with patients specific needs to understand their procedure.

Patients and their families could give feedback on the service and their treatment and staff have supported them to do this. Staff were able to give feedback following a procedure.

Patients gave positive feedback about the service. Patients described the staff professional and caring. "Things were explained to me before my procedure, next time I might ask for a smaller camera "

Is the service responsive?

Good

This was the first inspection of the service. We rated it as good.

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

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

Managers planned and organised services, so they met the changing needs of the local population. The hospital worked with the NHS during COVID1-19 and clinical commissioning groups to meet the needs of the local population. The service had an agreement in place with trusts. The service recognised change in their local area to assist the NHS to reduce a waiting time for a patient waiting for an endoscopy procedure.

Good

Medical care (Including older people's care)

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The service provided separated areas for male and female pods.

Facilities and premises were appropriate for the services being delivered. The areas were spacious and accessible for patients with wheelchairs for specific designed pathway for endoscopy appointments. Leaders and staff piloted a separate entrance during COVID-19 for endoscopy to separate patients for infection control and prevention.

The service had systems to help care for patients in need of additional support or specialist intervention. The service had staff specifically trained in areas, such as dementia and learning disabilities.

Managers monitored and took action to minimise missed appointments. Managers monitored appointments regularly to ensure patients were seen. Staff followed up missed appointments and rescheduled them.

Managers ensured that patients who did not attend appointments were contacted. Nurses told us patients were contacted for nonattendance at appointments. To keep patient safe, waiting for an endoscopy procedure they were rebooked within 28 days. Patients were contacted if they missed an appointment.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, a learning disability or dementia, received the necessary care to meet all their needs. The staff were trained and considered meeting the needs of patients with a learning disability and dementia. There was a dementia lead in place for support. The staff knew how to care for patients with specific needs. The service was able to book translators following a referral if required. The staff were able to access support and use external services.

Staff supported patients living with dementia and learning disabilities by using 'This is me' document. The 'This is me' supported the patient during an appointment and enabled the team to be aware of the patient's needs beforehand. Staff used forget me not sign to indicate that patients living with dementia may require additional support.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff prepared for appointments and explained procedures to them.

The service had information leaflets available in languages spoken by the patients and local community or were able to print information for patients in their native language.

If patients required a translator this was pre booked. We saw a patient requiring a translator in Mandarin.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters. The service was able to access interpreters.

Access and flow

Good

Medical care (Including older people's care)

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The service benched marked with other similar service within the group of their performance. Leaders told us they did well regionally from a referral to treatment for patients.

The service saw small numbers of NHS referrals of endoscopy procedures to reduce waiting times.

Managers worked to keep the number of cancelled appointments to a minimum. During COVID-19 mangers cancelled appointments due high numbers of sickness but assessed and re booked as soon as they could. The service considered safe staffing to keep patients safe with alternative appointments.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

Patients, relatives, and carers knew how to complain or raise concerns. The service displayed how to make a complaint in patient areas. Staff explained if patients raised a concern, they would action the issues and positively resolve.

Is the service well-led?

Good

This was the first inspection of the service. We rated it as good.

Leadership

Please see the surgery core service report for more hospital wide details culture.

Vision and Strategy

The service had a vision for what it wanted to achieve.

The leaders and team had a vision as overall service and further develop to the endoscopy area newly appointed an endoscopy lead. The service was working to achieve Joint Advisory Group on gastrointestinal endoscopy accreditation the endoscopy lead and national lead were working together to achieve this.

Please see the surgery core service report for more hospital wide details culture.

Culture

Please see the surgery core service report for more hospital wide details culture.

Good

Medical care (Including older people's care)

Governance

Please see the surgery core service report for more hospital wide details culture.

Management of risk, issues and performance

They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Leaders identified risks and were clearly recorded on the local risk register this included staffing and concerns with equipment. The service identified risks and actions were taken to mitigate risks. The endoscopy department had moved in June 2022 to Beacon Park Hospital. The service was not Joint Advisory Group on gastrointestinal endoscopy (JAG) accredited. This had been identified on the risk register. The hospital recruited a new endoscopy lead to support JAG accreditation for the future.

Information Management

Data or notifications were consistently submitted to external organisations as required.

Leaders were aware of reporting to agencies like CQC, local authorities and RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations).

Please see the surgery core service report for more hospital wide details culture.

Engagement

Please see the surgery core service report for more hospital wide details culture.

Learning, continuous improvement and innovation

Please see the surgery core service report for more hospital wide details culture.

Good

Diagnostic imaging

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

Is the service safe?

Good

The service has not been previously rated. We rated safe as good.

Mandatory training

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

Staff generally received and kept up-to-date with their mandatory training. Data received after the inspection showed that mandatory e-learning training compliance for all radiology staff was above the provider target of 85%. All radiology staff had received life support training with the last 12 months. The provider's training guidelines stated that this should be to the level of immediate life support (ILS) for radiographers. However, at the time the data was received, 2 radiographers had only received training at the level of basic life support, although ILS training had been booked in for 1 of the radiographers lacking this.

Staff told us that there are given time to complete their training within working hours.

The mandatory training was comprehensive and met the needs of patients and staff. In addition to life support training, staff received training on patient moving and handling, health, safety and welfare, equality and diversity, infection prevention and control, conflict resolution, workplace exposure to blood and body fluids, PREVENT, modern slavery, information security, data security awareness, fire safety and customer service excellence.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. This was the Oliver McGowan mandatory training on learning disability and autism, in addition to a dedicated dementia awareness module.

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

Safeguarding

Good

Diagnostic imaging

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. All radiology staff had received safeguarding adults training to levels 1 and 2, and safeguarding children training to levels 1 and 2 within the last 3 years as per provider guidelines.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke to could give examples of scenarios where they would report a safeguarding concern.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. A noticeboard outside theatres had contact numbers on for safeguarding both inside and outside of office hours.

Cleanliness, infection control and hygiene

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

Staff generally cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff mostly documented when they had cleaned the C-arm X-Ray machine and lead personal protective equipment after use on a monthly cleaning ticksheet, although there were some omissions. The C-arm X-Ray machine had been used on 18 days in January 2022, but the cleaning ticksheet was completed for only 13 days. At the time of inspection, 21 February 2023, the ticksheet had been filled in 4 times that month, but the service told us that the C-arm X-Ray machine had been used on 17 days in February. Therefore, we were not assured that the C-Arm was always cleaned and cleaning documented. The C-arm X-Ray machine had a green 'I am clean' sticker with the inspection day's date on it.

For further information, please refer to the surgery report.

Environment and equipment

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

The design of the environment followed national guidance. Warning signs were placed on the external doors to theatre where the C-arm X-Ray machine was operational, asking that staff only enter with permission due to theatre being a controlled area.

Staff generally carried out daily safety checks of specialist equipment. Staff mostly documented that they had completed daily checks of the C-arm X-Ray machine on a 'radiology tasks' ticksheet. The C-arm X-Ray machine had been used on 18 days in January 2022, but the 'radiology tasks' ticksheet was filled in for 13 days. At the time of inspection, 21 February 2023, the ticksheet had been filled in 4 times that month, but the service told us that the C-arm X-Ray machine had been used on 17 days in February. Therefore, we were not assured that daily checks were always completed or always documented.

We saw evidence that fluoroscopic (X-ray) testing of protective lead aprons, tops, skirts and collars had been carried out in October 2022, within the annual timeframe advised by the service's radiation protection advisor.

Good

Diagnostic imaging

The C-arm X-Ray machine had undergone its annual preventative maintenance service by the manufacturer in May 2022. We also saw evidence that staff had performed quality assurance testing on the machine in August 2022, November 2022 and January 2023, although the 'radiology tasks' ticksheet indicated that this should be a monthly task.

For further information, please refer to the surgery report.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks.

Staff knew about and dealt with any specific risk issues. The service had clear systems in place to ensure that risks were assessed and appropriately managed. A comprehensive radiation risk assessment for the C-arm X-Ray machine was present and up to date, and local rules were in place for theatre imaging. We saw evidence that all staff had signed a declaration sheet to say that they had read and understood the local rules. A flow chart was in place to manage the risk of pregnancy in patients undergoing imaging in theatre. The chart provided clear guidance on what action radiographers were to take in the event that that pregnancy status was not documented, including escalation procedures and incident reporting.

For patient deterioration, risk assessment on arrival, mental health support and handovers, please refer to surgery report.

Staffing

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

The service had enough staff to keep patients safe. The radiology service employed a radiology manager, 3 full time radiographers and a 1 part time radiographer. They also employed 2 bank radiographers on a regular basis. Staff rotated to Beacon Park Hospital from their base at Rowley Hall Hospital as required.

Managers told us that they could rely on bank staff to cover any shortfalls in staffing, for example when substantive staff were on annual leave.

The manager could adjust staffing levels according to the needs of patients. The service had a weekly planning meeting to ensure staffing covered theatre requirements for the week ahead and could adjust accordingly.

The service had no staff vacancies at the time of inspection.

The service had no turnover of staff between December 2022 and February 2023.

The service had reducing rates of hours worked by bank staff. Although the service did not provide hours worked by bank staff as a proportion of total hours, the number of hours worked by bank staff was reducing. In December 2022, 26.5 hours were worked by bank radiographers. In January 2023, this number was 15.5 hours and in February this was zero. The service did not use agency staff at the time of inspection.

Good

Diagnostic imaging

Managers limited their use of bank staff and requested staff familiar with the service. The 2 bank radiographers employed by the service undertook regular work.

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

Records

Please refer to surgery report.

Medicines

The service did not use contrast media or any other medicines in their work.

Please refer to surgery report.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and would report them appropriately. Managers would investigate incidents and share lessons learned with the whole team and the wider service. When things went wrong, staff would apologise and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Although there were no incidents reported concerning diagnostic imaging at Beacon Park Hospital, staff we spoke to could give examples of scenarios where they would put in an incident report. The incident reporting system was easily accessible to staff on the provider intranet.

The service had no never events.

Staff understood the duty of candour. Staff could explain what duty of candour is and the situations in which it applies.

Staff received feedback from investigation of incidents, both internal and external to the service. A monthly 'lessons learned' newsletter was produced by the diagnostic governance team which compiled learning from incidents and near misses throughout the provider's sites. The newsletter was sent out to radiology managers who cascaded it to their teams. The diagnostic governance team also produced provider-wide bulletins called 'Outcomes with Learning', known locally as OWLs, based on recurring issues across services, for example contrast reactions. The bulletins were sent to heads of departments and then disseminated to staff.

Is the service effective?

Good

The service has not been previously rated. We rated effective as good.

Evidence-based care and treatment

Good

Diagnostic imaging

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. All policies were viewed were comprehensive and up to date.

For information on the Mental Health Act 1983, please refer to surgery report.

Nutrition and hydration

Please refer to surgery report.

Pain relief

Please refer to surgery report.

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 was working towards accreditation under relevant clinical accreditation schemes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. This included audits of infection prevention and control including hand hygiene, personal dosimetry and mechanical equipment. We also saw evidence of a monthly safety 'walk-about', which included ensuring the environment was free of trip hazards, that personal protective equipment was available, and that staff were wearing it correctly.

The service did not routinely audit radiation doses given to patients against dose reference levels (DRL) at the time of inspection, but staff told us that a quarterly DRL audit was on the action plan from the most recent radiation protection advisor visit in February 2023. Staff told us about an ongoing focussed audit of doses for post-operative imaging of the pelvis with a prosthesis in situ versus pre-operative imaging of the pelvis.

Managers used information from the audits to improve care and treatment. Initial results from the focussed dose audit showed that the mean dose for 2 post-operative x-rays with a prosthesis in situ exceeded the local DRL. Managers contacted the service's medical physics expert immediately for advice. On investigation, it was shown that when the service when originally submitted data for 2 x-rays of the pelvis, pre-operative examination doses were included, as well as post-operative doses which skewed the local DRL, with a consequential lower than average local DRL. The service were advised that further data collection was necessary to correctly realign the local DRL. A number of technical dose reduction measures were also suggested which the service adopted.

Managers shared and made sure staff understood information from the audits.

Improvement is checked and monitored.

The service was working towards Quality Standard for Imaging accreditation.

For national audits and expected risk of readmission, please see surgery report.

Good

Diagnostic imaging

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. All radiographers had completed competency assessments which included understanding of ionising radiation safety, including Ionising Radiation (Medical Exposure) Regulations principles, and equipment competency including awareness of what to do in the event of equipment breakdown.

Managers gave all new staff a full induction tailored to their role before they started work. The induction was comprehensive, covering facilities and equipment, policies and protocols for the service and radiation safety.

Managers supported staff to develop through monthly 1:1 meetings. We saw evidence that managers discussed staff learning and achievements, plans for personal development, and any support that they needed. They also asked for ideas from staff as to how the service could be improved. The staff we spoke to felt that the 1:1 process was a valuable way to reflect on their current roles, and plan for their future development.

Managers made sure staff attended team meetings, but when this was not possible information was passed on during monthly 1:1s.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. One staff member spoke to was very pleased that they were able to undertake training to become a radiation protection supervisor, as well as fire warden training and a preventative maintenance course. Another staff member recently undertook a senior leadership course, and felt that the service provided good opportunities for career development.

Multidisciplinary working

Please refer to surgery report.

Seven-day services

The service was available between the hours of 8am and 8pm, Monday to Friday. Depending on activity levels, a Saturday service would be provided. The service did not operate an on call system.

Health promotion

Please refer to surgery report.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Good

Diagnostic imaging

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

Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. All radiology staff received and were up to date with training as part of their safeguarding adults training.

Please refer to surgery report for further information.

Is the service caring?

Good

The service has not been previously rated. We rated caring as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients in a respectful and considerate way.

Patients said staff treated them well and with kindness. Patients we spoke to after the inspection told us that the whole team in theatre, including the radiographer, introduced themselves before the procedure started and were kind and considerate throughout.

Staff followed policy to keep patient care and treatment confidential.

Emotional support

Please refer to surgery report.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Patients told us that the use of the C-arm X-Ray machine was explained to them before their procedure.

For informed and advanced decisions about care, and patient feedback, please refer to surgery report.

Is the service responsive?

Good

Diagnostic imaging

Good

The service has not been previously rated. We rated responsive as good.

Service delivery to meet the needs of local people

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

Managers generally planned and organised services so they met the changing needs of the local population. However, while some post-operative imaging could be undertaken by the service if required, not all imaging, for example chest x-rays, could be undertaken in the event of patient deterioration. Managers told us that patients would need to be transferred to their sister site or a local NHS trust for this service, but in the 3 months prior to the inspection on 21 February, this had not occurred.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required tests on one occasion. Staff told us that a system was in place to ensure that images acquired by other services were sent via an image exchange portal so that they were available to staff when patients attended the service.

Facilities and premises were appropriate for the services being delivered.

For mixed sex accommodation, mental health support, and missed appointments please see surgery report.

Meeting people's individual needs

Please refer to surgery report.

Access and flow

Please refer to surgery report.

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 clearly displayed information about how to raise a concern in patient areas. However, the service had not received any complaints in the 3 months prior to the inspection on 21 February.

Staff understood the policy on complaints and knew how to handle them. Staff told us that they would try to resolve a complaint at the time to the best of their ability. If the complaint was not resolved, they would refer the patient to the complaints procedure and the hospital governance team would deal with the complaint.

Good

Diagnostic imaging

Managers shared feedback from complaints with staff and learning was used to improve the service. Although there have not been any complaints about the service at Beacon Park Hospital, staff told us about a complaint regarding the use of a male chaperone in another part of the radiology service at Rowley Hall Hospital. The learning from the complaint has resulted in more information posters about chaperones being placed in the service, including Beacon Park Hospital.

Is the service well-led?

Good

The service has not been previously rated. We rated well-led 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. Staff told us that the service manager was approachable and communicated well with staff. They gave staff both positive and constructive feedback, and staff expressed that they felt safe in the service. Staff were encouraged to develop in their roles and further training was encouraged and supported.

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.

See surgery report.

Culture

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

Staff we spoke to described a positive, supportive culture in the service, with several staff saying that they felt the team had a family feel. The radiology manager felt that they were supported by senior hospital management, describing an 'open door' policy when needing to ask questions or raise issues. The service had a trained mental health first-aider, and 'speak up for safety champions'. All staff said they could raise concerns without fear of victimisation.

Governance

Good

Diagnostic imaging

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

The service had clear governance processes, and we saw evidence of involvement in governance activity with other services. Staff attended regional radiation protection and medical exposure committee meetings where they discussed subjects such as updates from radiation protection advisers and medical physics experts and provider policy updates, culminating in an action plan to be reviewed at the next meeting. The radiology manager attended clinical governance meetings, and a monthly heads of department meeting where compliments, complaints, incidents and lessons learned were discussed, as well as any updates to the hospital risk register. Staff told us that information from this meeting was fed back to them. We saw evidence that service staff attended resuscitation committee meetings which also had an associated action log.

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 generally had plans to cope with unexpected events.

The service had clear systems in place to identify and manage risks. The radiology service had a local risk register, and staff were aware of its contents. Staff told us that in the event of the C-arm X-Ray machine breaking down they did not have a spare machine on site, and that it would not be practical to transport another machine from another site. Therefore, imaging would not be available in the service until a repair was completed. In the event of an IT failure, staff told us that images would be safely stored on the C-arm X-Ray machine until they could be transferred onto the service's Picture Archiving and Communication System when a connection was restored.

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.

See surgery report.

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.

See surgery report.

Learning, continuous improvement and innovation

Good

Diagnostic imaging

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.

See surgery report.

Good

Surgery

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

Is the service safe?

Good

This was the first inspection of this core service. We rated it as good.

Mandatory training

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

All staff received and kept up to date with their mandatory training. At the time of our initial inspection in August 2022, only 82% of staff were up-to-date on their mandatory training which was below the provider's target of 85%. Staff at all levels said the COVID-19 pandemic had impacted on training provision and compliance, especially face to face training. The service commenced 2 days a month mandatory training session this year. During our follow up inspection in February 2023, we found 97.3% of staff had received mandatory training.

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

Manual handling.

Health and safety.

Fire safety.

Infection prevention and control.

Safeguarding adults and children.

Information security.

Consent.

Good

Surgery

Basic life support (BLS) for clinical staff.

Clinical staff completed training on recognising and responding to patients with mental health needs, a learning disability, autism and dementia. All staff had completed a dementia awareness training programme. Managers monitored mandatory training and alerted staff when they needed to update their training. Effective systems were in place to monitor overall training compliance and this was reported hospital wide.

All clinical and non-clinical bank staff had been contacted and if they had not worked in last few month or were not up to date on mandatory training, they were removed from the bank.

Safeguarding

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

All staff received training specific for their role on how to recognise and report abuse. For all eligible staff (including bank staff), there was safeguarding training compliance rate of 98.9% in February 2023.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff explained how the pre-assessment process captured all relevant risk factors.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Examples were given of appropriate recognition and escalation of indicators of abuse at patients' pre-assessments.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff demonstrated an effective awareness of the hospital's safeguarding processes and had received appropriate training for their grade. The hospital had a named safeguarding lead that was available for support and advice. Clear flowcharts were available for staff to follow to report any concerns about adult or child abuse to the hospital's safeguarding lead nurse, as well as giving relevant contact phone numbers for local authority safeguarding teams.

Staff were aware of potential risks and who to escalate any concerns to. A safeguarding lead with appropriate training was in place at the hospital. Safeguarding Information packs had been recently provided to all heads of department covering processes for responded to any child, adult or Prevent concerns. (Prevent is about safeguarding individuals from being drawn into terrorism, ensuring those vulnerable to extremist and terrorist narratives are given appropriate advice and support at an early stage.)

We noted that any safeguarding concerns identified by the hospital had been reported correctly and evidence of any required learning was applied if so required. CQC received no notifications of alleged abuse about this service in the 12 months prior to our inspection in February 2023. We reviewed 5 staff files and found all required recruitment checks, including Disclosure and Barring Service checks had been completed.

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.

Good

Surgery

All areas seen were visibly clean and had suitable furnishings which were clean and well-maintained. The day case surgery areas had suitable furnishings which were clean and well-maintained.

Appropriate systems and processes were in place to ensure the cleanliness of the hospital was maintained.

The service generally performed well for cleanliness. Cleaning records reviewed were up-to-date and demonstrated all areas were cleaned regularly. Checklists seen had been completed according to the hospital's policy.

Staff used records to identify how well the service prevented infections. Infection, prevention and control (IPC) processes were robust and well managed. Suitable posters were visible across the hospital, regarding IPC and COVID-19 precautions. Staff followed infection control principles including the use of personal protective equipment (PPE). COVID-19 precautions were effective in all areas visited and we saw there was effective compliance by staff and visitors with the hospital's IPC processes. There was a clearly defined COVID-19 pathway in operation from patients' arrival to discharge. Gel sanitiser and masks were readily available, and, at the hospital entrance, staff ensured visitors complied with the precautions. Staff were fully able to explain the COVID-19 precautions in their work areas, and actively encouraged all visitors to comply with them. No COVID-19 confirmed positive patients were being cared for in the areas that we visited. Appropriate isolation facilities were available for patients with a suspected infectious disease. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

The service had a utility room which contained clean urine bottles, a macerator and a commode. We saw no 'I am clean' sticker on the commode and could not be assured that this had been cleaned and readily available for patient use. We raised this immediately with senior staff who ensured this was checked and 'I am clean' stickers used. We saw 'I am clean' stickers appropriately used on all other equipment throughout the hospital.

Staff used disposable curtains in recovery areas and changed them every 6 months or if soiled. We saw evidence that these had been changed and dated within 6 months.

Staff worked effectively to prevent, identify and treat surgical site infections. We observed a theatre list and noted the theatre was cleaned down effectively post procedures. All staff were compliant with IPC precautions and wearing PPE at all times.

In the IPC governance and assurance inspection report dated 11 July 2022, the hospital achieved an overall compliance score of 89%. There was a service level agreement in place with a microbiologist for infection control and staff were aware of how to contact both them and the local and regional Public Health England centres. All IPC related incidents were recorded on the electronic risk system and that root cause analyses (RCAs) were carried out where applicable. The site engineer/operational manager ensured that legionella and pseudomonas safety and testing programmes were in place and that results were reported to the water safety committee and reviewed at IPC Committee. Standard PPE audits were carried out 3 monthly. Hand hygiene observation (5 moments) audits were completed on a monthly basis. The last 'Facility Assurance Inspection Report' (dated 26 February 2021) showed the hospital was 86% compliant. Actions arising from this report were in hand to complete the COVID-19 facility assurance audit and to update mandatory training records. Appropriate policies were in place such as 'Septic Technique Using Aseptic Non-Touch Technique (ANTT) as the Organisational Standard' and Methicillin-resistant Staphylococcus Aureus (MRSA) Screening and Management'.

There were facilities to ensure all patients with suspected or proven infection could be placed in a single room. There were procedures for deep cleaning and decontamination in place after discharge of patients who had been isolated.

Good

Surgery

In the 'Departmental Cleaning Audit (49 Steps) Inspection Report' dated 27 July 2022, the ambulatory care/day case service achieved 93% compliance. In the 'Departmental Cleaning Audit (49 steps) Inspection Report' dated 22 March 2022, the theatre service also achieved 93% compliance.

The hospital achieved 100% compliance in the Isolation Inspection Report dated 16 August 2022.

The hospital's theatres achieved 100% compliance in the 'Hand Hygiene Technique (Assurance) Inspection report dated 18 January 2022.

Hand hygiene observation audits showed the following compliance:

Ambulatory care/day case, 95% on 27 July 2022 and 100% on 17 August 2022.

Theatres, 100% on 22 March 2022.

The hospital achieved 100% in the 'Peripheral Venous Cannula Care Bundle Inspection Report' dated 12 August 2022.

The hospital achieved 92% in the 'Surgical Site Infection Inspection Report' dated 19 May 2022, and actions to further improve compliance were in place.

The hospital followed the provider's 'Infection Prevention and Control' policy (February 2022) to ensure that systems were in place to carry out mandatory monitoring of healthcare associated infections and other infections of local relevance, including resistant organisms; and ensure that the results were shared across the organisation and used to drive continuous quality improvement.

We noted that a detailed service level agreement was in place with an appropriate equipment sterile services' provider.

Environment and equipment

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

The design of the environment followed national guidance. The hospital provided day case procedures only. There were no inpatient beds. There was 1 theatre was an ultra-clean ventilation theatre theatre with adjoining anaesthetic room, preparation area and scrub area, clean and dirty endoscope rooms. Ultra-clean ventilation systems (which are designed to provide a zone around the patient that is effectively free of bacteria-carrying airborne particles while the operation is in progress) have been shown to significantly reduce surgical site infection in patients undergoing large joint replacement surgery. The theatre environment was visibly clean and tidy. All equipment was situated on suitable racking provided. The theatre and anaesthetic rooms were cleaned, and equipment stocked daily. Documentation was completed daily. A project was in place to improve the environment for disposable stores to be relocated.

Staff carried out daily safety checks of specialist equipment, including resuscitation equipment. No gaps in daily and weekly checks records were noted on equipment we reviewed. All equipment and clinical consumables viewed were fit for use. Clinical sterile supplies were provided by an external company. The recovery area consisted of 1st and 2nd stage recovery bays, clean and dirty utility rooms, changing rooms and a quiet room. The treatment room had adjoining clean and dirty utility rooms and toilet.

Good

Surgery

Instruments were decontaminated and sterilised in an accredited central sterilisation unit which was compliant with quality management systems. An instrument traceability system was in use. There were defined mechanisms in place for recognising sterile integrity of instrumentation. Sterile instruments were stored in a clean, dry, dust free environment. There was a defined process to change instruments if contamination was identified.

The service had enough suitable equipment to help them to safely care for patients. Staff carried out daily safety checks of specialist equipment. In areas visited, we did not find any unsuitable equipment and all necessary maintenance checks had been carried out, including for hoists. Staff reported appropriate access to equipment.

Staff disposed of clinical waste safely. Appropriate facilities were in place for storage and disposal of household and clinical waste, including 'sharps'. A 'sharps' bin is a container that can be filled with used medical needles and all categories of 'sharps' waste, before being disposed of safely. 'Sharps' bins seen were appropriately labelled and stored correctly. We saw that regular ward audits were carried out and any shortfalls identified and addressed. Appropriate segregation of household and clinical waste took place with secure storage areas viewed outside the back of the hospital. The hospital achieved 97% compliance in the 'Sharps Inspection Report' dated 28 June 2022.

Staff had access to the medical devices equipment asset and testing portal. We noted that the hospital's governance meetings included reference to medical devices and monitoring of equipment logs. We noted the service was on track in delivering its actions in the environmental action plan.

The service had enough suitable equipment to help them safely care for patients. Piped oxygen and suction equipment was available at each bed space within the first stage recovery area, as well as call buttons for emergency use.

A 'Health Technical Memorandum Water 004-01 Water Risk Assessment' was in place dated 15 February 2022 with an appropriate action plan to mitigate risks of water systems infections.

In the 'Facilities/Health and Safety Audit Summary' dated 15 February 2022, the hospital achieved 95% compliance. The fire safety element of this audit achieved 93% compliance. A detailed fire risk assessment was in place valid to 21 April 2023. The service followed the provider's detailed fire manual, which had a review date of June 2025. Firefighting equipment seen was fit for purpose.

Service visits were carried out in accordance with the 'Health Technical Memorandum 03-01 (2021): Specialised ventilation for healthcare premises Part B: The management, operation, maintenance and routine testing of existing healthcare ventilation systems'. Air change rates in the theatre were compliant with national parameters as per the service visit on 27 July 2022.

We noted one storage cupboard was unlocked and had Control of Substance Hazardous to Health (COSHH) chemicals inside during our initial inspection in August 2022. COSHH is the law that requires employers to control substances that are hazardous to health. We raised this with staff, who took immediate actions to address this and to also raise awareness throughout the staff team. During our inspection in February 2023, all 4 storage cupboards were locked in locked rooms.

Cleaning equipment was colour coded in line with National Patient Safety Agency recommendations. Colour coding of hospital cleaning materials and equipment ensured that these items were not used in multiple areas, therefore reducing the risk of cross-infection. Housekeeping staff adhered to the colour coded mop and bucket system to avoid cross-contamination. A housekeeping staff said they used red mops to clean toilets, blue to clean general areas and yellow in theatres.

A spillage kit was available in the clean utility room and theatre. Staff used these to clean blood and bodily fluid spillage.

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 completed risk assessments for each patient on admission/arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff knew about and dealt with any specific risk issues including sepsis, venous thromboembolism risks, falls and pressure ulcers. We review the electronic records system and saw that comprehensive risk assessments were carried out at pre-assessment consultations with each patient, and that these were regularly reviewed and updated as and when required. The electronic system in use gave a complete audit trail for each patient throughout their period of care and treatment at the hospital. Patient pre-assessments were carried out at Beacon Park Hospital.

We saw that pre-operative assessments included the patient's medical history, vital signs recorded, advice about diet prior to surgery, that any comorbidities were recorded, COVID-19 risk assessments were completed, all relevant risk assessments were completed, dementia screening assessments were completed and that pre-operative tests taken were taken in accordance with national guidance.

Staff used a 'Risk Escalation Tool' to identify patient co-morbidities from the patient health questionnaire that required further information from the patient. This would identify the requirement for investigations, diagnostics and possible escalation for clinical review and action before the patient was confirmed fit for surgery. Patients who were at risk were considered for multidisciplinary review.

The service could access mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). This would be escalated to the hospital's residential medical office as and when required. Staff knew how to complete, or could arrange, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Staff shared key information to keep patients safe when handing over their care to others. There was appropriate liaison and communication with patients' GPs and NHS acute trust referral teams during the episode of care and treatment delivered. Shift changes and handovers included all necessary key information to keep patients safe. Daily safety huddles, which were recorded, took place each shift, where all essential information was cascaded appropriately.

We noted the hospital followed the 'Transfer of Critically Unwell Patient' procedure (dated September 2021). Where transfer was required, three principles were observed:

· 'The potential benefits of any transfer must be weighed against the clinical risks.

· No transfer is so urgent as to compromise the safety of the patient or staff.

· Staff undertaking transfers must have the required level of knowledge and competence.'

Good

Surgery

Staff used the National Early Warning Score (NEWS) to identify deteriorating patients in accordance with the National Institute for Health and Care Excellence (NICE) Clinical Guidance (CG) 50: 'Acutely ill adults in hospital: recognising and responding to deterioration' (2007). We saw a 'Track and Trigger' recognition of unwell patients on the wall in the patient recovery area which guided staff on how to score and asked staff about actions they had taken where NEWS was greater than 1. The chart provided clear guidance on NEWS and staff knew how to use this.

Staff were fully aware of the risk of sepsis. The hospitals followed the provider's 'Recognition and Management of the Deteriorating Patient' clinical procedure providing staff with the tools to assist in identifying a deteriorating patient/ resident and to enable them to take appropriate action ensuring the patient's safety at all times. Staff said they had regular awareness sessions. There had been 1 patient transfer out from Beacon Park Hospital to an acute NHS trust from September 2022 to January 2023.

All clinical staff had BLS training annually. For all eligible staff (including bank staff), there was BLS training compliance rate of 93%. Advanced life support (ALS) training was required for anaesthetists 4 yearly with regular short updates. For all eligible staff, there was ALS training compliance rate of 100%. All other consultants were required to have Immediate life support training (ILS) 3 yearly, with annual updates. For all eligible staff, there was ILS training compliance rate of 49% in August 2022. Leaders had plans in place to address this with extra training being laid on. ILS compliance had increased from 49% to 62% at the time of our inspection in February 2023 and this was still below the provider's target of 85%. Three staff had been booked to attend the ILS training in March 2023 and had attended the BLS as an interim. This was to ensure availability of appropriate numbers of BLS/ILS trained staff to cover the resus team requirements.

The service had introduced a blood storage unit/fridge on site which was not yet in use and had a service level agreement with the local blood bank. This was to facilitate blood availability to patients who required transfusion prior to being transferred to an acute trust. Training around usage, handling and storage was being delivered to staff.

The hospital carried out frequent audits of World Health Organisation (WHO) Surgical Safety checklist compliance. We observed a team brief during the inspection. All theatre team involved in patient care were present and involved. All patients were discussed individually, including their procedure; allergies; patient name, and the order of the list was also discussed. No changes were to be undertaken. All information was documented on the hospital's electronic database (as per policy). We observed completion of the WHO checklist including all 3 completed stages. All staff were engaged in each stage and spoke up when questions were asked. All information was documented on the electronic database (as per policy). We viewed the debrief in theatre. All staff that had been involved in the patients' care during the list was present and involved. All information was documented on the electronic database (as per policy). All disposables were counted by 2 members of the theatre team pre and post op as per regulations and documented on the board provided. All instruments were also checked by using the paper sheet provided with the instruments. The swab checks were competed appropriately.

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. Staffing levels met patients' needs on the day of the inspection. The service had enough nursing and support staff to keep patients safe on the day of the inspection. The service had low and reducing vacancy rates. Most staff rotated between Rowley Hall and Beacon Park Hospital which gave flexibility and cover where necessary.

Good

Surgery

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants (HCAs) needed for each shift in accordance with national guidance. Electronic staff rostering was completed 4 to 6 weeks in advance to allow for robust staff management and planning, ensuring substantive and bank staff were available to enhance safety and offer continuity. Managers could adjust staffing levels daily according to the needs of patients. The number of nurses and HCAs matched the planned numbers at the time of the inspection.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. The service had low rates of bank and agency nurse use with 2.6% bank staff use. There were a number of bank members of staff who worked within all departments to cover vacancies, sickness and annual leave. There were adverts out for bank staff at the time of the inspection.

Daily staffing was displayed on a notice board and contained actual staffing for the resuscitation team coordinator, surgeon, scrub and shift coordinator to ensure awareness of who was on duty.

A new scrub lead had recently been appointed. They ensured a staffing rota was available 4 weeks in advance. Full-time staff worked their contracted hours over 3 long days from 7.30am to 8pm. Staff worked flexibly around their needs.

Medical staffing

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

Patient care and procedures were consultant led. The service had enough medical staff to keep patients safe. Resident Medical Officers (RMOs) worked on a weekly rotation at both hospitals. RMOs at Beacon Park Hospital worked 7.30am to 8pm. All RMOs had ALS training. The medical staff matched the planned number in documents seen. An emergency out of hours telephone number was available and a pager for emergencies. All senior managers took turns being on the on-call rota and could be contacted when required for advice and support. Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

The service always had a consultant on call during evenings and weekends. An emergency out of hours telephone number was available and a pager for emergencies. All senior managers took turns being on the on-call rota and could be contacted when required for advice and support.

Consultants were appointed under a practicing privileges basis and the surgical lists were planned in accordance with their availability.

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 very comprehensive, and all staff could access them very easily. The hospital used the provider's electronic patient record system for all aspects of the service provided from pre-assessment, through to contemporaneous notes of care interventions and treatment provided. We case tracked 4 patients records and saw that all required records and assessments had been completed. Staff confidently navigated the electronic system to demonstrate the various risk assessments and documents. The electronic system was easy to navigate.

Good

Surgery

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

Records were stored securely. All computers were left locked when not in use. Audits were carried out and any learning shared.

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. Medicines' management subcommittee meetings took place and reported into the hospital's quality governance meeting. We noted that all audits were up to date for July 2022 and a recent Home Office controlled drugs (CD) visit at Beacon Park Hospital had gone well. We saw the CD cupboard in theatres was well maintained and contained no expired medicines.

The service had a pharmacy technician who worked across both sites and a pharmacy stock management system had been changed to a provider specific system and this was running effectively. The recent heatwave caused some concerns regarding the room temperatures and temperatures on the resuscitation trolleys. Appropriate measures had been introduced to ensure the integrity of the medications. Stock was well managed with no issues reported that had resulted in any patient cancellations.

Staff monitored room and medicines fridge temperatures and recorded them once every 24 hours. Daily readings were all in range and the maximum and minimum temperatures were read.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. We saw theatre staff checked the dates on all medicines prior to use. Staff completed medicines records accurately and kept them up-to-date. Records seen confirmed this. Staff stored and managed all medicines and prescribing documents safely. Appropriate, secure storage facilities were in place. Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Staff learned from safety alerts and incidents to improve practice. All staff received regular safety updates and we noted these were also discussed in team meetings. The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Pre-operative risk assessments included screening for people with a dementia.

A corporate pharmacy team provided support with prescriptions and investigations which involved medicines management.

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 raised concerns and reported incidents and near misses in line with the provider's policy. Staff were confident in raising issues and concerns. Staff were aware of the incident reporting process. The hospital reviewed all incidents and took the required actions needed to address and mitigate any potential risks.

Good

Surgery

Senior staff had introduced an active speaking up for safety programme which empowered all staff to report incidents without fear of victimisation. We noticed a serious incident had recently been reported and senior staff followed the right procedures when dealing with the incident.

The service had no never events. Managers shared learning about never events with their staff and across the trust. Managers shared learning with their staff about never events that happened elsewhere.

Staff reported serious incidents clearly and in line with trust policy. Operational performance and patient safety data were collated and reviewed at the hospital's senior leadership team meetings. Actions were identified and owners assigned to complete any required actions.

Staff understood the duty of candour which is 'that as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.' They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff were fully able to explain how duty of candour principles would be applied. We noted the hospital maintained a duty of candour log and used a detailed checklist for all potential incidents.

Staff received feedback from investigation of incidents, both internal and external to the service in line with the provider's policy. Staff met to discuss the feedback and look at improvements to patient care at the daily safety huddles and at handover meetings. The hospital followed the provider's 'Being Open' policy (next due for review in 2023) which aimed to improve the quality and consistency of communication when patients were involved in an incident by ensuring that, if mistakes were made, patients and/or their relative/carers receive promptly the information they need to enable them to understand what happened by following a clear process.

The hospital followed the provider's 'Investigating Serious Incidents' policy to give clear guidance for staff involved in investigating serious incidents to ensure there were learnings from serious incidents and appropriate actions were taken to improve patient safety.

The hospital director and head of clinical services reviewed lessons learned and cascaded them through the local Medical Advisory Committee to all consultants, local Clinical Governance Committee, Resuscitation Committee and Clinical Heads of Departments. We reviewed 3 RCAs reports for reported incidents and found the investigations were thorough and timely. Appropriate lessons had been identified and effective actions plans were in place to support improvements. Themes and actions from RCAs were routinely discussed at head of department, governance and Medical Advisory Committee meetings.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers debriefed and supported staff after any serious incident. Staff used the safety data to further improve services. Local leaders reviewed their team's performance with regard to the hospital's dashboard and areas for improvement were cascaded throughout staff teams.

All incidents were reported using an electronic database. We noted that all reported incidents were discussed at the hospital's governance meetings and appropriate actions taken. There had been 14 reported incidents across both hospitals from January 2022 to January 2023 with a trend of month on month decrease in number of incidents. A thematic analysis was shared with heads of department for cascade. A Duty of Candour log was in place to evidence

Good

Surgery

compliance with the regulations and a checklist was in place to support with the process. We noted the 'Clinical Governance Meeting' minutes of 28 July 2022 contained an overview of recent incidents, learning and ongoing actions required with the staff responsible and appropriate timescales. The 'Theatre Team' meeting minutes we saw of 6 July 2022 contained details of issues raised and actions required.

Is the service effective?

Good

This was the first inspection of this core service. 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. Policies seen were reflective of national guidance. We saw regular policy updates were provided centrally via the provider's central alert system. This included monthly updates on National Institute for Health and Care Excellence (NICE). We saw these were discussed at the hospital's quality governance meeting. Staff could access policies easily. We noted the 'Clinical Governance Meeting' minutes of 28 July 2022 contained updates on new and updated policies and also updates on NICE guidance. The provider's 'NICE Guidance April - June 2022' contained a thorough list of all new and updated guidelines highlighting those for implementation, discussion at Medical Advisory Committee or to note for information.

A comprehensive clinical audit programme was in place for 2022/23 covering all departments, the required frequency and deadlines for complete. We noted that a new theatres' audit programme had been distributed and all heads of department were familiarising themselves with this new programme and were monitoring that all required monthly audits were being completed.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. At handover and huddle meetings, staff referred to the psychological and emotional needs of patients, their relatives and carers when required.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

The hospital provided day case services only. There were no inpatient beds. Staff made sure patients had enough to drink including those with specialist and hydration needs. Patients confirmed this. We saw that patients in recovery had their hydration needs met. Staff fully and accurately completed patients' records where needed. Staff used a nationally

recognised screening tool to monitor patients at risk of malnutrition if required. We saw that these risk assessments were reviewed regularly. Specialist support from staff, such as dietitians and speech and language therapists, could be arranged if so required. This was considered as part of the pre-assessment process. Patients waiting to have surgery were not left nil by mouth for long periods. Patients confirmed this.

Pain relief

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

Staff assessed patients' pain using a recognised tool called 'analgesic ladder' and gave pain relief in line with individual needs and best practice. Patients received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately if required. Records reviewed and patient feedback to us confirmed this.

The Ramsay Surgical Pain Management policy issued in August 2022 covered the pain assessment tool. Senior staff were in the process of setting up a pain working group led by a clinical quality manager.

Where patients complained of feeling sick after surgery, staff prescribed anti-sickness medication to relieve their symptoms. Staff only discharged patients' home if they were medically fit for discharge.

Patient outcomes

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

The service participated in relevant national clinical audits. Outcomes for patients were generally positive, consistent and met expectations, such as national standards. Given the day case service provided, 'Patient Reported Outcome Measures' were not available for this hospital.

The National safety standards for invasive procedures (NatSSIPS) cover all invasive procedures including those performed outside of the operating department. In August 2022 the audits were 100% compliant.

All theatre staff showed good awareness of NatSSIPS. Managers and staff used the results to improve patients' outcomes. We saw frequent review of activity and outcomes discussed at the regular Heads of Department and Clinical Governance meetings. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits. Improvement were checked and monitored.

Staff and leaders followed the provider's 'Perfect ward' audit system which was thorough and showed all audits to be carried out and the frequency. Staff had training to use this system available.

Competent staff

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

Good

Surgery

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. Staff all said they had received both corporate and local inductions, which had met their needs. We saw evidence of local induction for a new starter and contained introduction to a buddy, hours of duty and information on location of key policies.

Senior staff supported the learning and development needs of staff. Managers made sure staff attended team meetings or had access to full notes when they could not attend. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. Managers identified poor staff performance promptly and supported staff to improve. A range of additional training was available from the provider, including managing our people, health and safety representatives, risk management, autism and learning disability awareness, mental health first aider, and leading with influence.

The hospital followed the provider's 'Continuing Professional Development' policy (dated May 2018) to ensure all staff were in an environment where managers were committed to providing a culture of continuing professional development. We saw completed performance development review forms included reflections on the past year, objectives review and setting, behaviours, plans for the next year and referenced the provider's competency framework. The hospital followed the provider's 'Performance Development Review policy (dated June 2009 with next review date December 2022) to promote best practice in managing the formal review of staff performance. This policy had not been reviewed at the time of our inspection in February 2023.

The hospital followed the provider's procedures for ensuring all consultants had appropriate practising privileges arrangements, including medical indemnity cover. A practising privilege is the 'licence' agreed between individual medical practitioners and private healthcare providers and governs the range of surgery they are competent to perform. The provider's 'Facility Rules' took effect from 30 September 2019 and applied to all hospitals and clinical facilities operated by the provider. These 'Facility Rules' set out a minimum level of standards and requirements necessary to achieve the best outcomes for consultants, patients and the provider. We saw that a well-defined local process was in place for applications for practising privileges. To maintain accreditation with the hospital, accredited healthcare professionals with practising privileges were required to routinely provide evidence to support ongoing oversight of their practice, including professional registration, mandatory training, medical indemnity cover and appraisals.

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. At 9am daily, a whole "Hospital Huddle" with all senior leaders was held to discuss the resuscitation team for the day; any staffing issues; any concerns; the activity for the day; any safeguarding issues; finance and any complaints and complements from friends and family feedback.

Every morning there was a theatre department huddle with the whole team to discuss the theatre lists and any issues from previous day; theatre lists and cases for the present day; confirm which person was holding the 'crash' bleep for the day; key issues from the main hospital huddle and then everybody was asked if they have any other issues or positives to highlight. All this information was then emailed to all relevant staff.

Good

Surgery

Staff worked across health care disciplines and with other agencies when required to care for patients. Communication systems with the local NHS trust and GPs were effective. Staff knew how to refer patients for mental health assessments when they showed signs of mental ill health, depression.

Seven-day services

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

Beacon Park Hospital provided a day case service, 6 days a week. There were no inpatient beds. The residential medical officers worked throughout the day, 7.30am to 8pm. Patients were reviewed by consultants as part of their care pathway. Staff could call for support from doctors and other services, including mental health services and diagnostic tests, 24 hours a day, 7 days a week if so required. The theatres operated 6 days a week at the time of the inspection.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units. Staff assessed each patient's health as part of the pre-assessment consultation and on admission and provided support for any individual needs to live a healthier lifestyle as required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance. Records reviewed and staff and patient feedback confirmed this. If patients could not give consent, staff were aware of how to make decisions in their best interest, taking into account patients' wishes, culture and traditions. The hospital confirmed that no recent Mental Capacity Act assessments or best interests' decisions had had to be made, given the nature of the patient population served.

Staff made sure patients consented to treatment based on all the information available and this was an integral part of the pre-assessment consultation. Staff clearly recorded consent in the patients' records. There was a thorough audit trail in the electronic patient records we viewed. Consent was taken in clinic at least two weeks prior to admission then patient was re-consented on day of surgery as per requirements.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. As of 3 March 2023, the average training compliance for these courses across the service was 98.23%. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Managers were aware of the implications of the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them if so

Good

Surgery

required. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Managers were aware of the implications of the use of the Mental Capacity Act and made changes to practice when necessary. Staff demonstrated an understanding of Deprivation of Liberty Safeguards in line with approved documentation.

Is the service caring?

Good

This was the first inspection of this core service. We rated it as good.

Compassionate care

Staff always treated patients with great compassion and kindness, respected their privacy and dignity, and always proactively took account of their individual needs in a holistic, person centred way.

Staff were very discreet and very responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw a number of positive, caring interventions by staff, who always took their time to ensure patients' needs were understood and met appropriately. Staff were very proud of the care they gave. From our observations, all staff were very pleasant and polite to patients, other colleagues and to all visitors.

All patients said staff treated them well and with kindness. Feedback from all patients spoken with was universally positive about the all the staff. Visitors were very complimentary about the service provided by staff. Feedback from patients included:

'Staff make you feel comfortable.'

'What lovely people, I felt so comfortable and looked after'.

'A first class service'.

'The facilities are excellent'.

'There is a really good team here'.

Staff followed policy to keep patient care and treatment confidential. We saw staff respect and maintain patients' privacy and dignity at all times. Staff were able to give us a good summary of the patients under their care.

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. They gave an example of how they facilitated a procedure for a patient living with autism and how they ensured care was tailored to their specific need.

Good

Surgery

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff knew the needs of each individual patient very well and provided a very person-centred approach to the care they delivered. Patients were provided with verbal and written information about the risks of surgical site infections associated with their operation. This included how and when they should report problems with their wound.

The hospitals used an electronic system to capture real time patient feedback using a number of patient experience survey systems. The combined data for the hospitals in July 2022 showed they performed better that the provider's national average.

'Respect and dignity' feedback, 100%, better than the provider's average of 96%.

Private Healthcare Information Network (PHIN) patient experience, 95%, better than the provider's average of 92%.

Hospital Friends and Family Test, 100%, better than the provider's average of 94%.

Net Promoter score (which measures customer experience), 98, better than the provider's average of 80.

The hospitals kept a compliments log which showed that from January to August 2022, 77 compliments had been received from patients. We noted the universally positive patient experiences from 11 feedback forms for the hospital's hysteroscopy service in the period March to August 2022.

Emotional support

Staff provided excellent personalised emotional support to patients, families and carers to minimise their distress. They fully 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 told us who they would support patients and we saw positive examples during the inspection. Staff were very empathetic and caring.

Staff provided appropriate care to those patients that were in communal areas, such as the reception area, in line with their needs assessed needs and care planning. Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff displayed great empathy on all care interactions we saw. Staff gave examples from the COVID-19 pandemic of how sensitive information was relayed to patients and their relatives.

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. Senior staff informed new staff during their induction to always bear in mind that for them it might be an ordinary day but an extraordinary day for the patient and their relatives.

Staff used a holistic, person centred approach to each individual patient, and took time to get to know them and their needs and wishes. Staff provided a tour of the department to patients who were anxious about their procedure prior to their appointment date as required.

Patients were complimentary about the care they had received. Communication from the hospital staff was felt to be excellent and informative.

Staff took patients who were anxious either prior or post procedure to a quiet room which enabled them to have more privacy and dignity.

Good

Surgery

The service had a system in place which enabled them to flag up patients' emotional needs on the patients' electronic record. Staff said where a patient was found to be anxious, they created time to listen and spend time with them to understand the reason for anxiety.

Understanding and involvement of patients and those close to them

All staff supported all patients, families and carers to fully understand their condition and make decisions about their care and treatment. Feedback was extremely positive.

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with confirmed this; they knew exactly would stage their treatment was at, and who to call for in case they needed more information. Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff were very kind and friendly to all patients and any visitors.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff were very proud of the feedback their patients gave. Staff supported patients to make informed decisions and advanced decisions about their care. Patients gave positive feedback about the service. We spoke with three patients during the inspection. All were very complimentary about the staff, the care they gave, the timeliness of care being given, the environment and availability of car parking.

A respect and dignity survey for July 2022 showed 98% patient satisfaction, slightly above the provider's national average.

Staff gave an example of how they provided emotional support to a relative while they waited for their loved one living with dementia and undergoing a surgical procedure.

Is the service responsive?

Good

This was the first inspection of this core service. 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 service was seeing a number of NHS patients to help alleviate the 'backlog' in referrals locally, as arranged with local commissioners. The service worked with local NHS trusts to help locally with NHS elective backlogs. Leaders were exploring implementing different types of service across both hospitals to reflect needs of the local community and to continue to support local NHS providers, especially with the national drive for elective recovery. Appropriate contracts were in place with 7 local commissioning groups for treating NHS funded patients for:

Elective gastroenterology.

Good

Surgery

Acute cataract surgery.

Acute gynaecology services.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. No inpatient facilities were offered at this hospital. Facilities and premises were appropriate for the services being delivered. Staff could access emergency mental health support 24 hours a day 7 days a week for patients. The service had systems to help care for patients in need of additional support or specialist intervention. The provider is looking to expand services at Beacon Park Hospital.

Managers monitored and took action to minimise missed appointments. Managers ensured that patients who did not attend appointments were contacted. Administration staff rebooked appointments for patients who did not attend. Patients who did not attend their appointment twice were referred back to their GP.

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, a learning disability or dementia, received the necessary care to meet all their needs and appropriate risk assessments were in place. All patients had their needs thoroughly assessed prior to treatment. Dementia screening was completed as indicated and concerns were highlighted, and an alert would be added to the medical records system. The hospital had a comprehensive 3 year 'Dementia Strategy' in place which was focused on improving the care and experience of people living with dementia and their carers by delivering a holistic, person-centred care philosophy.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had had training and access to appropriate communication materials. Staff followed the provider's comprehensive policy to support 'Patients Who Require Additional Support to Access Information and Services' (August 2022), with clear guidance on assessment of needs, support required and designed to ensure complied with the Accessible Information Standard, formally known as DCB1605 Accessible Information.

The service had access to information leaflets available in languages spoken by the patients and local community. We saw information leaflets for cataract, retinal detachment, foot surgery and wound care displayed in the patient waiting area.

Managers made sure staff, and patients and carers could get help from interpreters or signers when needed. Staff had access to communication aids to help patients become partners in their care and treatment.

Patients were given choice of appointment times to meet their needs. Regular bookings meetings were held across both hospital services.

Detailed standard operating procedures (SOPs) were in place to determine which patients were suitable for surgical procedures at the hospital, for example, the 'Rowley Hall & Beacon Park Hospital General Anaesthetic and Spinal

Anaesthetic Guidance' (dated October 2020). This SOP documented the patient criteria for Rowley Hall and Beacon Park Hospital. All patients were individually assessed. Any clinical concerns relating to the patient's fitness to proceed to surgery was escalated for anaesthetist review and/or consultant surgeon, as appropriate. Staff excluded patients if they were are unable to provide an appropriate and safe clinical environment.

On the day of our inspection in February 2023, 3 out of 4 patients undergoing cataract surgery told us they had only received a phone call about their appointment and no general information relating to cataract surgery. We raised this with senior staff who checked and said all patients on the cataract theatre list for cataract had been pre-assessed and seen by a consultant in the outpatients' department.

Access and flow

People could mostly 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. Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The surgical waiting list over 52 weeks was 5.97%. The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment (RTT). The surgical waiting list within 18 weeks was 52.78% in March 2023.

Managers used a clear clinical prioritisation process to review the waiting list periodically and actively sought the views and wishes of patients. A detailed action plan was in place for both hospitals setting out key delivery milestones for monitoring and reducing the RTT waiting lists, with weekly and monthly reporting.

From information provided, as of 3 March 2023, the hospital had a waiting list comprising:

0-18 weeks: 729 patients.

18-26 weeks: 159 patients.

26-40 weeks: 193 patients.

40-52 weeks: 90 patients.

52-65 weeks: 71 patients.

65-78 weeks: 14 patients.

78-104 weeks: 5 patients.

Some of the patients on the waiting had been booked to attend in March 2023.

From information provided, activity at Beacon Park Hospital from August 2021 to August 2022 was:

Good

Surgery

NHS – 3,470 patients.

Private medical insurance – 136 patients.

Self-paying patients – 126 patients.

The highest number of procedures undertaken (and outpatient appointments) was for orthopaedics and the hospital were supporting the local NHS trust with the elective backlog.

There were no returns to theatre for Beacon Park Hospital 12 months prior to our inspection in February 2023.

Managers and staff worked to make sure patients did not stay longer than they needed to. Theatre lists generally had 7 to 15 patients on them as procedures were generally non-complex. For cataract procedures, lists had 12 to 15 patients seen and treated. For pain management lists, usually there was around 7 patients seen and treated.

Managers worked to keep the number of cancelled treatments/operations to a minimum. When patients had their treatments/operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. For 2022, there had been 739 cancellations. Some of these procedures had to be cancelled due to insufficient number of patients booked.

Managers proactively reviewed these and ensured re-bookings were made. We noted there was an immediate review taking place regarding the one non-clinical cancellation that occurred on the day. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Staff supported patients when they were referred or transferred between services. Managers monitored patient transfers and followed national standards.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. Patient feedback confirmed this. The service clearly displayed information about how to raise a concern in patient areas. Appropriate information was available to patients and visitors. Staff understood the policy on complaints and knew how to handle them. Local leaders confirmed that there had been a reduction in complaints over the past few months and that all complainants were offered an initial early conversation to understand the issue at hand and to clarify any expectations. Almost all complaints were resolved quite quickly by this proactive approach and rarely did they progress to stage 2 of the hospital's complaints' process. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We reviewed 2 recent complaint response letters and saw investigations of the issues raised were thorough. Managers investigated and shared feedback from complaints with staff and learning was used to improve the service. Any complaints and compliments were discussed at the daily safety huddles and at handover meetings. Staff could give examples of how they used patient feedback to improve daily practice. We saw that the hospitals had received 10 compliments from July 2022 to February 2023. Themes included very kind and caring staff, and excellent treatment. The hospitals received 1 complaint in September 2022 and 1 in January 2023. The complaints were around ongoing pain following surgery and a cancellation due to the list overrunning. No particular trends were noted and there had been a variety of reasons. There were no overdue complaints at the time of the inspection.

Good

Surgery

The hospitals received 11 compliments in April 2022, 10 in May 2022 and 14 in June 2022.

There was evidence that changes had been made as a result of feedback. Recently the hospital had introduced the 'you said, we did' principles to staff suggestions and feedback received.

Is the service well-led?

Good

This was the first inspection of this core service. We rated it as good.

Leadership

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

The senior management team were very experienced, visible, supportive and clearly knew their staff and their patients. The hospitals' senior leadership team (SLT) worked cohesively and inclusively across both hospital sites and comprised a Hospital Director, Hospital Manager, Operations Manager, Finance Manager, Head of Clinical Services, HR and Training Manager, Theatre Lead, Ward Manager, Outpatients Manager, Radiology Manager, Governance Lead, Pharmacy lead, Receptionist Lead, Physiotherapy lead and a Business Office/Stores lead. They were highly compassionate and kind to each other and to all staff. They appeared to be a very cohesive team working hard for the benefit of all patients, staff and their service. Leaders were proud of their joined-up approach. They had an ambitious vision for the future and stated they were very proud of their staff and the hard work they have put in during the COVID-19 pandemic. Recruitment, retention and support for staff was clearly of concern, especially in theatres, and leaders were fully aware this and had plans to address this. We saw very passionate, committed matrons and local managers throughout the service.

Consultants were fully engaged and committed to deliver the best possible services for their patients. Consultants highlighted that since the new governance lead started, they felt much more supported and any issues they highlighted were being dealt with. For example, advertising and employment of staff. Leaders spoke of an away day planned for September 2022. Leaders worked very closely together and shared their knowledge and skills to support each other and the wider staff team. Leadership development training was available from the provider.

Leaders were proud of each other and the feedback they received from staff. Leaders had a nurturing and developmental approach to support all staff. Staff spoke of a caring atmosphere to work in, down to the culture of teamwork and sharing which they felt was extremely strong. The ward manager was praised for their particular approach to teamwork and commented on some of the improvements that they have implemented since starting. Staff reported senior leaders were approachable and visible. Staff commended senior leaders for the compassionate way they supported staff and their families that were directly impacted by COVID-19.

Vision and Strategy

Good

Surgery

The service had a well-developed vision for what it wanted to achieve and a comprehensive strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were fully focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff fully understood and knew how to apply them and monitor progress effectively.

The hospital had embedded the provider's values and focused on maintaining the highest standards of quality and safety, being an employer of choice, and operating its business according to 'The Ramsay Way' philosophy:

"People Caring for People": "The "Ramsay Way" culture recognises that people – staff and doctors – are Ramsay Health Care's most important asset and this has been key to the organisation's ongoing success. Our absolute focus on delivering the best outcomes for our patients, maintaining the highest level of engagement and respect for our doctors, and our continued drive on clinical excellence and innovation our hospitals remain the number one choice for doctors and patients."

The values of the provider were well embedded across the hospital and all staff were familiar with them. Staff were proud to work at this hospital. Beacon Park Hospitals adopted and embedded the values of the 'Ramsay Way' and leaders ensured these were 'lived' everyday by a clear focus on these values:

'we are caring'.

'sustainability'.

'work together'.

'we have pride'

'value people'.

'positive outcomes'.

Leaders had the local vision of being recognised 'as the premiere provider of healthcare in our catchment area, offering a broad range of high-quality services and proven outcomes to patients, whatever the method of funding'.

The hospitals had a strategy in place covering the period to 2030 with a focus on developing the services provided across the hospitals. This aligned with the provider's national strategy and was adapted to meet local need, including supporting the local NHS trust to respond to increasing needs in elective care, due to the impact of the COVID-19 pandemic. The strategy promoted inclusivity and respecting diversity and had a clear overarching focus on the safety and quality of services delivered. Leaders were well appraised of the provider's national strategy and their role in helping deliver it.

Leaders also were embedding the provider's updated 'Sustainability Strategy' which aimed to offer high-quality health care under 'The Ramsay Way' ensuring 'our people, our planet and our communities are all well cared for'.

Culture

Good

Surgery

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

All staff at all grades, were always very friendly and very welcoming and we had open and honest conversations with a wide variety of staff across the service. We saw there was a real community feel to the hospital. Leaders promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Almost all staff said they trusted the local leadership team and almost all felt able to raise concerns with them. There was a very strong sense of teamwork which encouraged candour, openness and honesty. They spoke very highly of their staff having a 'can do attitude' and their willingness to help each other. Theatre staff spoke of an inclusive, supportive culture.

Beacon Park Hospital had embedded the 'Speaking up for Safety' (SUFS) programme, developed by an internationally recognised healthcare safety organisation. SUFS was a programme to build a culture of safety and quality by empowering staff to support each other and raise concerns. SUFS formed part of the mandatory training for all staff and informed discussions at the daily huddle which had representation from all areas of both hospitals. Leaders checked that staff were aware of the provider's policy 'Speaking Up for Safety (SUFS)' (March 2022). Leaders appropriately addressed behaviour that undermined patient, and staff safety. One of the SLT had undertaken the provider's SUFS trainer/deliverer course and was proactively supporting all staff to raise awareness and drive improvements across the whole hospital.

We noted that a staff mental health and wellbeing plan was in place at both hospitals. Leaders were committed to improving and maintaining the mental health and well-being of all staff by promoting awareness of mental health and providing support for staff through different programmes. Three qualified mental health first aiders were available for staff to access at Beacon Park Hospital. Staff also had access to a trained counsellor who was available for 1:1's when required. The provider also offered an employee assistance programme that was free to all employees and could be accessed without referral to occupational health. Leaders actively promoted this service and encouraged staff to use whenever necessary. There was a range of information available to staff via the provider's intranet including for mental health and wellbeing, and occupational health.

Leaders held various celebration/awareness days. Leaders recognised staff successes. We saw that various members of the staff team had been recognised for their work by receiving one of the hospital's 'Healthcare Heroes' monthly awards. Staff were also recognised for their long service by getting an award.

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.

A governance system was in place with the production of detailed information about the service's performance, which was discussed at regular governance meetings and used to demonstrate effectiveness and progress across the service. Minutes seen described the performance and safety issues for the service clearly and any actions required to improve the service were identified appropriately. Local leaders confirmed that key messages were cascaded throughout staff teams.

Good

Surgery

At Beacon Park Hospital, the quality governance agenda was led by a team consisting of the Head of Clinical Services, the newly appointed Quality Governance Lead and Quality Governance Coordinator. The team were working to ensure that all governance requirements and reporting were met and that continual improvement and commitment to quality remains central to all services. The governance structure in place included:

Monthly Clinical Governance Committee and quarterly integrated governance committee to review incident trends and complaints, with 12 subcommittees meeting monthly.

Monthly departmental review meetings with Head of Clinical Services (HOCS), Finance Manager and Human Resources, discussing quality, safety and risk.

Efficient reporting of incidents and management of risk and trends by Matrons, Hospital Manager, Hospital Director, Outpatients HOD and Ward Manager, monitored daily by HOCS. Staff underwent reporting training as part of their induction and clear expectations were set around efficient reporting of incidents.

Hospital risk register which was reviewed in monthly risk and board meeting'.

Health and safety, IPC meetings, endoscopy, medical device and best practice meetings (all subcommittees) and a daily leadership huddle was held.

Electronic staff rostering was completed 4 to 6 weeks in advance to allow for robust staff management and planning, ensuring substantive and bank staff were available to enhance safety and offer continuity.

Weekly activity planning meetings were held each Tuesday. Up to 8 weeks of theatre lists were reviewed to ensure sufficient equipment was ordered and staffing was organised.

There was a Medical Advisory Committee (MAC) with a chair, vice chair and eight members. Clear terms of reference were in place. The MAC meeting minutes of 16 June 2022 showed detailed consideration of impacts of COVID-19, a review of learning from recent complaints and incidents, and updates on consultants' practising priveledges' compliance. The hospitals helds monthly Heads of Department Meetings to review performance and risks and to drive improvements. Minutes seen showed they were well attended and had a standing agenda, covering general updates, activity reports, lessons learned for incidents and complaints, audit results, anf finanical forecasts. The hospitals held Clinical Governance Meetings quarterly and minutes seen showed they were well attended and covered a range of topics to drive improvements across services. Actions were identified and assigned to the relevant staff to carry out.

We reviewed a variety of meeting minutes including from team meetings, theatre meetings, HODS meetings, SLT meetings and saw effective records of discussion about incidents and feedback received, issues raised, actions delivered and required with clear onward tasking of actions, via action logs where needed. All members of the theatre team we spoke were aware of the governance structure.

Management of risk, issues and performance

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

Good

Surgery

Leaders monitored referral to treatment (RTT) performance and at the time of our inspection in August 2022 and February 2023, a significant number of patients had been waiting over 18 weeks. Only 52.78% of patients had received treatment within 18 weeks of RTT. Although an action plan was in place, we were not assured on how leaders intended to reduce the waiting list.

Leaders were fully aware of the risks in the service notably the staffing pressures particularly pronounced in theatres. Longer term plans to improve services were in place, but at the time of the inspection, these outcomes had not yet been delivered. Leaders maintained an appropriate risk register, which defined the severity and likelihood of risks in their services causing potential harm to patients or staff. They documented the measures to be taken to reduce the risk. We saw the risks reflected the concerns described by staff in the service. Staff knew how to report and escalate risks. Staff said the risk registers were reviewed frequently by the leadership team and severe risks were escalated to the provider's regional support team as required. There was a detailed and comprehensive risk register in place for the theatre unit, which had been reviewed regularly. Clear mitigations were in place for the 7 ongoing risk entries. This fed into the overarching hospital risk register, which again was detailed and contained clear risk scoring, effective mitigations and timely reviews as required. The risk register was routinely discussed at governance meetings and HOD meetings. All members of the theatre team we spoke were aware of the risk register and mitigations in place.

The hospital followed the provider's 'Risk Management' policy which aimed to improve the quality and consistency of communication when patients were involved in an incident by ensuring that, if mistakes were made, patients and/or their relative/carers receive promptly the information they need to enable them to understand what happened by following a clear process.

Incidents were reviewed at SLT, Head of Department and Clinical Governance meetings also at MAC, Health and Safety and IPC Meetings and via team meetings. Information regarding incidents was displayed on notice boards in staff areas to ensure awareness and sharing of learning.

Audit completion was monitored via the quality governance meetings, with all departments required to provide an update on progress with compliance and delivery of their action plans.

We noted that the provider had produced a quarterly report in December 2020 upon the COVID-19 impacts for patients' experience. This had provided valuable insights for the hospitals own services.

Teams held regular team meetings and we saw that patient feedback, performance and delivery and learning from incidents was discussed and documented. A whole hospitals approach was used to cascade learning across different teams.

Leaders checked that all staff followed the provider's procedures, for example, 'Moving and Handling' procedure and we saw thorough risk assessments were in place.

Information Management

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

Good

Surgery

Staff received helpful data on a regular basis, which supported them to adjust and improve performance as necessary. Staff generally had access to up-to-date, accurate, and comprehensive information on patients' care and treatment. Staff were aware of how to use and store confidential information. Appropriate notifications were made to external organisations when required. CQC received 3 appropriate statutory notifications for the service in the period of 12 months prior to our inspection in August 2022, in accordance with the regulations.

The hospitals used an electronic system to capture real time patient feedback using a number of patient experience survey systems, including the Private Healthcare Information Network Patient Experience, Hospital Friends and Family Test and NET Promoter. Data was used to identify the hospitals' best performing areas and opportunities for improvements.

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 leadership team engaged with staff and aimed to ensure all their voices were heard and acted on to shape services and the culture. The service gathered feedback from staff through a variety of forums and methods. Almost all staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and managers.

Views and experiences of patients and those close to them were gathered and acted on to shape and improve the service. A patient forum was being established with a terms of reference and standing meeting agenda developed. The service was identifying patients who may wish to attend.

All staff we met on inspection said it was a good place to work, with good support from management. All staff said that they felt comfortable to speak to the hospital management team. They also knew the names and who the senior team were. A recent staff survey showed levels of engagement were comparable to the provider's national average and that overall, staff understood their job and recognised the provider's focus on high quality care. Local actions to feed into the provider's ongoing action plan were being taken, including enhancing cooperation between teams and change management.

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.

Staff and leaders were committed to innovation and were following the provider's national policy 'Introduction of New and Evolving Techniques, Medical Devices, Medicines and Therapies'.

In response to the COVID-19 pandemic, the hospital put specific measures in place to protect patients and staff. An assurance process was used to check the effectiveness of these measures protect patient safety. This included peri-operative Polymerase Chain Reaction swabs to check effectiveness of shielding and swabbing pre-operatively, post-operative calls to check on COVID-19 status and the outcomes of surgery to check effectiveness of shielding and

Good

Surgery

pathway precautions, testing of staff who crossed green and amber pathways in different geographical facilities; and staff working with any immunocompromised patients for a 6-week period to check effectiveness of precautions and PPE use. Leaders ensured all staff were made aware of the provider's regular 'clinical flash communication to the organisation; key points' which highlighted key steps and timescales.

Good

Outpatients

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

Is the service safe?

Good

This was our first inspection of this service. We rated it as good because:

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it but this had been impacted by the pressures of the COVID-19 pandemic across the hospital in some areas.

The mandatory training provided was comprehensive and met the needs of patients and staff. However, the hospital target for training across all sites including the outpatient's department for completion was 90% and evidence we received following the inspection showed this target was not being met for safeguarding training or basic and advanced life support training. Evidence we received following the inspection explained that staff who had missed mandatory training due to the impact of the COVID-19 pandemic will be up to date by the end of this year. Any bank staff who have not completed training would be removed from the bank staff register.

Training included a corporate induction which was undertaken by all staff. Other training modules included basic life support, immediate life support, fire safety, infection control and consent. The service had an electronic system for monitoring completed training and to alert staff when training was due to be completed.

Clinical staff completed training on recognising and responding to patients with mental health needs, a learning disability, autism and dementia. All staff completed mental capacity training which included training in dementia and learning disabilities.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. The service provided training to most staff on how to recognise and report abuse.

Most staff received training specific for their role on how to recognise and report abuse. Clinical staff received safeguarding training for adults and children to level 3 and non-clinical staff to level 2. Evidence received following our inspection showed 81% of staff completed this training against a target of 90%. The service explained that the COVID-19 pandemic impacted on training provision for safeguarding but that plans were in place to update this training and achieve the service target levels for completion by the end of October 2022.

Staff gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff we spoke to knew how to make a safeguarding referral and who to inform if they had concerns. The service had a named safeguarding lead and staff knew how to escalate concerns. One staff member described an occasion where a patient had displayed behaviours of being confused and disorientated, the staff member had discussed concerns about the patient with the safeguarding lead and a referral for a follow up assessment had been made.

The service kept a log of all safeguarding concerns raised to be able to ensure appropriate procedures had been followed in line with the service policy. The service discussed safeguarding concerns and referrals at the clinical governance meeting and we saw details of actions taken.

Posters and information leaflets were displayed in staff areas with information about safeguarding procedures and actions to be taken if staff had any concerns.

Leaders recruited staff safely within departments, this included an enhanced Disclosure and Barring Service certificate, history of employment and references, followed by a comprehensive induction and training.

Cleanliness, infection control and hygiene

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

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. All areas in the outpatient's department were visibly clean. The utility rooms and dirty and clean laundries were well organised and clean. Cleaning schedules had been completed daily and were up to date. We saw cleaning staff were checking and cleaning patient areas at regular intervals during the day.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw staff using PPE and infection prevention control measures such as handwashing and use of antibacterial hand gel effectively. Staff following COVID-19 infection precautions and were able to explain the infection prevention control policy. The hand hygiene audit score for July 2022 was 95% which was above the service target. The audit also detailed actions to be taken to achieve a score of 100%.

There were information leaflets and posters in the patient areas detailing infection prevention control measures. We saw patients taking a COVID-19 test on arrival, prior to being seen by medical staff. There were adequate supplies of antibacterial hand gel, antibacterial wipes and face masks in all areas of the unit including at the main patient entrance.

Environment and equipment

Good

Outpatients

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

The design of the environment followed national guidance. The environment was clean and spacious. The service reception area and outpatient rooms were well organised.

The service had enough suitable equipment to safely care for patients. We checked a range of electrical equipment and found they had all been safety tested within required timescales. Staff carried out daily safety checks of specialist equipment. We saw evidence of regular equipment checks and audits on medicine fridges, utility room temperature and kitchen fridges.

The service had suitable facilities to meet the needs of patients' families. There was ample parking for patients directly in front of the building which was easily accessible. The unit was on one level and accessible for patients with reduced mobility.

The service had enough suitable equipment to help them to safely care for patients. Patients waiting to be discharged following an outpatient procedure could reach call bells and staff responded quickly when called.

Staff disposed of clinical waste safely. An external service collected all clinical waste via a service door at the rear of the building. However, during our inspection we noted that the door to the area designated for the collection clinical waste was open with the padlock not locked this meant it could be accessed by unauthorised personnel. The clinical waste bins inside the area were secure and locked. We bought this to the attention of the hospital manager at the time of our inspection and following our inspection we received assurance that action had been taken to keep this area locked.

There service had a fob door access system for security which meant that non-personnel could not move freely around the unit without a fob. However, during our inspection we noted that several rooms were not locked this included the intravenous medication store cupboard, the specimen room and the cleaning cupboard. This was bought to the attention of the hospital manager at the time of our inspection and we were assured action had been taken and the doors locked.

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 completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments were completed at the pre-assessment stage and during an assessment appointment. Any patient transferred to the service as part of an agreement with an NHS organisation was reassessed to assure nothing had changed with their health during the waiting period.

Staff responded promptly to any sudden deterioration in a patient's health. Staff were able to describe the pathway for a deteriorating patient and the escalation process and gave examples of situations when the pathway had been used. There was a resident medical officer on site during clinic hours and there was a specific pathway for these patients for additional support. In the event of a patient becoming too unwell to be discharged home they would either be transferred to the sister hospital at Rowley Hall Hospital or 999 would be called and transfer requested to the NHS trust.

Good

Outpatients

Staff knew about and dealt with any specific risk issues including sepsis, venous thromboembolism and falls. The service also completed dementia screening on all patients over 75 years of age and there was a pathway for these patients providing additional support. The service had a named dementia lead and staff were able to explain this role and the additional training provided to them.

The service had access to mental health liaison and specialist mental health support. Any patient assessed as needing addition support for mental health, dementia or learning and disabilities was discussed at a multidisciplinary team meeting including the consultant in charge of the patient's treatment, the mental health lead, safeguarding lead and dementia lead for the service

Staff shared key information to keep patients safe when handing over their care to others. Staff complete a discharge checklist with each patient which was stored electronically. Patients were given a copy of their discharge letter, information on aftercare and what to do if they become unwell. Referring agencies such as NHS trusts or GP's were informed of appointments and outcomes and discharges.

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.

Staffing in the outpatients department consisted of three health care assistants and two registered nurses.

Managers held a daily meeting to discuss staffing levels and these could be adjusted across departments as needed and offering support to the hospital's sister site at Rowley Park.

Managers attended monthly meetings to discuss staffing levels, recruitment and any actions to be taken to ensure the safety of patients. Staffing rotas were completed 4-6 weeks in advance to allow for robust staff management and planning, ensuring substantive and bank staff were available to enhance safety and offer continuity.

The need for bank staff to cover shifts was low. At the time of our inspection the service had no vacancies within the outpatient's department. The service had a low rate of staff turnover.

The service offered practicing privileges to consultants subject to a range of checks being completed. 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.

The service had an overall sickness rate of 8% most of which had been due to COVID-19 infections.

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.

Good

Outpatients

Patient notes were comprehensive and all staff could access them easily. We viewed four sets of patient records, all records were complete and up to date including clinical assessments, medicines and allergies. All the records had been signed and dated by the consultant in charge of the patients care and consent to treatment had been signed by the patient. We noted that the consent forms had been reviewed at a later stage following the initial consent, so patients had been asked for consent again prior to a procedure.

When patients transferred to a new team, there were no delays in staff accessing their records. Records were scanned immediately after an appointment onto the service electronic system and could be accessed easily.

Records were stored securely in a locked room and following appointments scanned onto the electronic system and sent for secure storage off site. All staff had separate logins for the records system.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, some medicines were not stored securely.

Staff followed systems and processes to prescribe and administer medicines safely. Staff completed medicines records accurately and kept them up-to-date. We viewed 5 medicine charts during our inspection, and all had been signed and dated and had appropriate instructions where medication was to be taken after a medical procedure.

We saw that prescription prescribing pads were locked away securely and there was a record for monitoring when and by who prescriptions had been used.

Not all drugs were stored securely. During the inspection we noted the intravenous medication store cupboard which contained medications such as intravenous contrast for procedures used regularly in computerized tomography (CT) scans was not locked. These medicines are a hazard if ingested and are produced in glass bottles which could also be a risk of injury. This was bought to the attention of the hospital manager at the time of our inspection and we were assured action had been taken and the doors locked.

Incidents

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the service's policy. Staff reported serious incidents clearly and in line with the service's policy. The service had an electronic system for reporting incidents and staff could explain the reporting process and how outcomes and learning from incidents were shared with them.

The service reviewed all incidents and themes and outcomes were shared with staff. The managers held meetings to discuss incidents and share learning with other departments. Learning from incidents was shared with staff during team meetings and team briefings.

Good

Outpatients

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Managers at the service were able to give instances where they would apply duty of candour.

Staff met to discuss the feedback and look at improvements to patient care. Incidents were discussed at local and national meetings. Learning from incidents was shared with staff at team meeting and via newsletters. Evidence we saw following our inspection showed the service had reported 8 incidents in July 2022 and that these had been reviewed for themes such as incidents relating to COVID-19 infections.

The service had reported no never events.

Is the service effective?

Inspected but not rated

We do not rate effective for this core service.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. 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. Staff we spoke to during our inspection were able to demonstrate their knowledge of the service policies and procedures. New policies were issued at provider level to managers and staff were then informed of these changes during staff huddles or electronically.

Managers and staff used polices to protect and care for patients such as, but not limited to, safeguarding vulnerable adults, infection control, mental capacity and assessing a deteriorating patient.

Nutrition and hydration

Staff gave patients enough drink to meet their needs and improve their health. However, staff at the service told us that they are not able to offer food to any patients which could be a risk for a patient who attends for an extended appointment time or had dietary needs for example diabetes.

Patients told us they had been given a drink and were able to request more if needed. The service said there were plans for food to be available in the future for patients.

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 prescribed, administered and recorded pain relief accurately. We saw that pain charts were completed correctly, and that information was available to patients on managing their pain this included keeping pain diaries for discussion at appointments.

Patient outcomes

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

Outcomes for patients were positive, consistent and met expectations, such as national standards. The service used an electronic system for recording and monitoring patient outcomes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. There was a clinical audit schedule with a timeline for each schedule to be completed and the ownership for completion. Audits included cleaning, hand hygiene, infection prevention and control cpdand aseptic non-touch techniques. In the audit completed in August 2022 for the handling of specimens the service scored 100% with no follow up actions to be taken.

Managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits. For example, an audit on sharps bins for the service had found some actions to be taken and these had been photographed for review and follow up with staff.

Please see the surgery core service report for more hospital wide details of patient outcomes.

Competent staff

The service made sure staff were competent for their roles. Managers appraised most staff's work performance and held supervision meetings with them to provide support and development. The service had policies in place to support staff to develop through yearly, constructive appraisals of their work. Staff we spoke to said they had one to one supervision with their manager and were able to discuss development or training needs at these sessions. However, evidence we saw following our inspection showed that the overall completion rates for personal development reviews for the hospital including its sister site at Rowley Hall Hospital was 73.1%.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. We saw evidence that all staff were offered a full induction, this included bank and agency staff.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. A staff member we spoke to explained that they have a daily staff 'huddle' meeting which is a brief daily meeting for information updates and then also a monthly team meeting.

Managers made sure staff received any specialist training for their role. Staff at the service engaged in continuing professional development reviews (CPD) as part of their personal development review. The CPD tool was used to ensure compliance for clinical staff with training, learning and maintaining professional skills and was reviewed by the manager.

Good

Outpatients

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 worked across health care disciplines and with other agencies when required to care for patients. The staff in the department worked well together and with other departments withing the hospital such as surgery and diagnostic imaging.

The department interacted with other departments to optimise patient care. Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. For example staff held meetings with dementia leads and mental health needs where necessary. Staff also worked with external services such as GP surgeries for the ongoing care of patients.

Seven-day services

Key services were available to support timely patient care.

The provider operated clinics 6 days a week. Consultants ran their clinics at different times in the morning or afternoon.

Staff could call for support from doctors and other disciplines.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas. Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle. We saw leaflets readily available for patients on smoking cessation, nutrition and healing and preventing deep vein thrombosis. Staff we spoke to at the service explained they would discuss improving health with patients and where appropriate refer patients to their own GP for smoking cessation support.

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 were able to explain how they would assess the needs of a patient who would not be able to consent to treatment and a multi-disciplinary meeting would be held to agree the best care plan for the patient.

Good

Outpatients

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records. We viewed four sets of patient records and all had a signed and dated consent forms. We noted that the consent forms had been reviewed again at a later stage following the initial consent and prior to the procedure.

The service provided all staff with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. This training was included training in the safeguarding training. Evidence received following our inspection showed only 81% of staff had been able to complete this training. The service explained that the COVID-19 pandemic had impacted on training provision for safeguarding training but that plans were in place to update this training and achieve the service target levels for completion.

Staff could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards and knew who to contact for advice.

Is the service caring?

Good

This was our first inspection of this service. We rated it as good because:

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. During our inspection we observed staff talking to patients in a discreet and considerate way.

Patients we spoke to said staff treated them well and with kindness. Staff followed policy to keep patient care and treatment confidential. We saw patients were booked in by the receptionist at the service when arriving for their appointment, the consultation process was explained clearly and the greeting they received was warm and friendly. Patients told us that their treatment was explained to them by clinical staff and they had opportunities to ask questions about their care. Patients said they would recommend the service and the staff.

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 understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff told us they completed dementia training and that there was a dementia lead available at the service. The service screened anyone over the age of 75 for dementia and discussed screening outcomes at a multidisciplinary team meeting to help meet the needs of the patients.

Emotional support

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

Good

Outpatients

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff explained treatment procedures clearly and patients we spoke to said they felt able to ask questions or ask for help.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Patients told us they had opportunities to ask questions about their care and treatment and that staff were understand of their concerns.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service. The service provided leaflets and posters in all areas for patients to give feedback on their care and treatment. Following our inspection, we saw evidence of patient survey results which were positive and reflected well on the service and staff.

Is the service responsive?

Good

This was our first inspection of this service. We rated it as good because:

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the changing needs of the local population. The service had been commissioned by the local NHS trust and clinical commissioning group to provide treatments for patients on the NHS trust waiting list. The service worked with the NHS trust and clinical commissioning group to review this agreement and the needs of the patients at a weekly contract meeting. The service had also been commissioned by the local community trust to provide an ear nose and throat clinic for local community patients as this had been a growing need in the area.

Facilities and premises were appropriate for the services being delivered. The building and facilities were easily accessible for patients with reduced mobility. The service had male and female changing rooms and lockers for personal belongings were available.

The service had systems to help care for patients in need of additional support or specialist intervention. The service had a named dementia lead and access to mental health liaison and specialist mental health support. Any patient assessed as needing addition support for either mental health, dementia or learning and disabilities would be discussed at a multidisciplinary team meeting including the consultant in charge of the patients treatment, the mental health lead, safeguarding lead and dementia lead for the service.

Managers ensured that patients who did not attend appointments were contacted. Patients who did not attend appointment were contacted and offered a further appointment. If patients missed a second appointment the referring agency for example their general practitioner would be advised.

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 were aware at the pre-assessment stage of patients living with dementia. There was documentation for families to complete prior to the appointment explaining the individual needs of the patient. Staff had access to a dementia lead for support.

The service had access to information leaflets available in languages spoken by the patients and local community. These could be printed off when needed, there were no leaflets in other languages available in the patient areas.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. One staff member we spoke to was able to describe the process for capturing the patient's language needs at the pre-assessment stage of the referral process and then booking an interpreter. This would be done by the administration team.

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. Patients accessed the service using a choose and book system and were able to book appointment to suit their needs.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. At the time of our inspection the service had no patients on the waiting list. Managers worked to keep the number of cancelled appointments to a minimum. The service had a pathway for monitoring cancellations and appointments where patients did not attend. Patients who missed a first appointment would be offered a second appointment. Patients who missed a second appointment or refused to be treated were referred to their general practitioner or referring treatment service.

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

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. During our inspection we saw leaflet in the waiting rooms for patients to provide feedback and posters with contact details.

Good

Outpatients

Staff understood the policy on complaints and knew how to handle them. All complaints were recorded electronically, tracked to ensure they were responded to within the service deadline and discussed at a weekly complaints meeting.

Managers investigated complaints and identified themes. Managers were able to describe the complaint process and the policy to us, following our inspection we saw evidence of responses to patients who had made complaints and details of the investigation.

Managers shared feedback from complaints with staff and learning was used to improve the service. Compliments and complaints were discussed at the daily staff huddle meeting and ways of improving were discussed and implemented.

Is the service well-led?

Good

This was our first inspection of this service. We rated it as good because:

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.

The service had a clear leadership structure both locally and nationally. Leaders at the service were experienced for the role. Staff we spoke to spoke highly of the leadership at the service and stated they felt able to approach both the local and national senor leadership team with concerns or suggestions. There was an outpatients manager who reported to the hospital managers.

Please see the surgery core service report for more hospital wide details of leadership.

Vision and Strategy

The service had a vision for what it wanted to achieve and a five year strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The service vision and strategy were on display in key areas of the service with information available for patients. Staff we spoke to understood the vision and strategy for the service and were able to describe this to us clearly.

Please see the surgery core service report for more hospital wide details of the vision and strategy.

Culture

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

Staff told us they felt they enjoyed working at the service and felt supported by the team and the leadership team. Staff also said that local managers were proactive and addressed concerns quickly and sought resolution.

Good

Outpatients

The provider Ramsay Health Care UK Operations Limited had implemented a hospital wide Speak Up For Safety programme. The programme had been developed with partner organisations to promote a culture of safety reliability and professional accountability. The aim of the programme was to encourage staff to raise concerns about safety or within services.

Please see the surgery core service report for more hospital wide details culture.

Governance

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

The service managed and kept records well including patients' records. Local information technology systems were used effectively for the management of records and staff files.

The service completed regular audits including infection prevention control, hand hygiene, antiseptic non-though technique and safe storage of clinical sharps. We saw evidence of audits and actions taken, such as the safe storage of clinical sharps audit had noted that sharps bin lids had been left open, there was photographic evidence of this, and details of the action taken to reduce risks.

Minutes we saw from the quarterly medical advisory committee details discussion were held by leaders covering infections prevention control, complaints, staffing, local audit outcomes and risks to the service. Local teams also held head of department meetings weekly and monthly meetings with the local NHS trust and commissioning leads. The provider produced a quarterly report to provide assurance on quality and safety. The report provided details on the governance structure, such as new staff appointments, when clinical and departmental meetings were held which reviewed staffing, safety and risk. The report also tracked incident themes, outcome and actions taken.

Please see the surgery core service report for more hospital wide details of governance.

Management of risk, issues and performance

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

The provider used a hospital wide system Centralised Alert System to monitor, implement and ensure the effectiveness of changes in policy and procedures implemented as a response to national or regional alerts from governing bodies and to ensure patient safety.

The service had a backup generator to provide power for equipment in the event of a power outage and there was a contingency for water supply to be uninterrupted. The service information technology systems had an alternate server which could be used in the event that the IT systems were unavailable therefore patient records and important information could still be accessed in the event of an emergency.

Good

Outpatients

The service had a local risk register and was able to demonstrate actions taken to mitigate risks. The main three risks were described as there being no clinical lead for the endoscopy service, transferring to the new information technology system and staffing levels. The service was recruiting for the clinical lead and staff in other areas and had done a test of the new IT system at another site and had a backup IT system.

The service had effective policies and procedures in place for protecting patients and staff from risk for example infection prevention control and sharps equipment policy.

Evidence of audits we saw following our inspection showed that these were completed on a regular basis and finding were recorded, reported and actions taken. For example, an audit on sharps bins for the service had found some actions to be taken and these had been photographed for review. The service had a plan for actions to be taken and dates for completion.

Information Management

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

The service stored data securely and computer systems were password protected. Staff could access the information they needed quickly and efficiently and this was demonstrated to the inspection team.

The service used data to analyse performance and make improvements. Data gathered was shared with staff and the wider hospital group for learning.

Engagement

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

The service encouraged feedback from patients and staff. We saw patient feedback from May to August 2022 the service scored highly on the patient feedback with a score of 99.4% for respect and dignity, 93.3% for patient experience and they also monitored areas for improvement and actions to be taken.

The service attended weekly, monthly and quarterly meetings with the local NHS trust and commissioning leads to discuss offering appointment to patients on waiting lists and reducing the wait time for these patients.

A patient forum was planned to be launched in September 2022 and feedback from patients would be used to develop and improve services.

Managers at the service used an action planning tool to improve patient experience and the satisfaction of staff.

Learning, continuous improvement and innovation

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

Good

Outpatients

The provider Ramsay Health Care UK Operations Limited had implemented a hospital wide Speak Up For Safety programme. The programme had been developed with partner organisations to promote a culture of safety reliability and professional accountability. The aim of the programme was to encourage staff to raise concerns about safety within services.

The provider newsletter which was circulated to all staff across the hospital highlighted 'unsung heroes' who had performed above expectation in their roles and celebrated staff with long service awards. The newsletter also highlighted areas for improvement and themes such as mental health awareness week and world hand hygiene day.

Please see the surgery core service report for more hospital wide details of the learning, continuous improvement and innovation.