

Spire Healthcare Limited

Spire Murrayfield Hospital

Inspection report

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

Ratings

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

Summary of findings

Overall summary

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

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

However:

In Surgery;

- The World Health Organization (WHO) checklist did not have the safety checks documented for the 'sign-out' section in one of the patient records we looked at. Staff told us that there were occasions when surgeons did not stay for the final sign-out step.

In Outpatients;





- Staff did not know how to refer patients to appropriate services to support them with their mental health.
- Staff did not always receive all the information they needed about a patient from the medical records team.

In Diagnostic Imaging;

- The service did not have individual key card access to medicine stock cupboards (as in other areas of the hospital).
- The service did not have adapted chairs in the waiting room for patients with mobility issues or who may not be able to sit in lower chairs.
- The service did not have learning disability and dementia-friendly adjustments in the department, as seen in other areas of the hospital.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	<p>Diagnostic imaging is a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.</p> <p>This inspection was the first time we inspected diagnostic imaging separately from other core services in the hospital.</p> <p>We rated this service as good because it was safe, caring, responsive and well-led. We inspect but do not rate effective for diagnostic imaging.</p>
Medical care (Including older people's care)	Good 	<p>Medical care services were a small proportion of hospital activity. This included endoscopy. The main service provided by this hospital was surgery. Where arrangements were the same, we have reported findings in the surgery section.</p> <p>This inspection was the first time we inspected medical care separately from other core services in the hospital.</p> <p>We rated this service as good because it was safe, caring, responsive and well-led.</p>
Surgery	Good 	<p>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.</p> <p>Our rating of this service improved. We rated it as good because it was safe, effective, caring, responsive and well-led.</p>
Outpatients	Good 	<p>Outpatients is a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.</p> <p>This inspection was the first time we inspected the outpatients service separately from other core services in the hospital. We rated this service as good because it was safe, caring, responsive and well-led. We inspect but do not rate effective for outpatients.</p>

Summary of findings

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Summary of this inspection

Background to Spire Murrayfield Hospital

Spire Murrayfield Hospital is operated by Spire Healthcare Limited and located in Thingwall, Wirral. The hospital provides services for NHS, private and self-funding patients, over the age of 18 for outpatient, diagnostic, inpatient and day case surgical care. The specialities include general surgery, orthopaedic surgery, ear, nose and throat (ENT) surgery, vascular surgery, cardiology, gastroenterology, spinal surgery, urology and maxillo-facial surgery.

The hospital provides care and treatment to adults across Merseyside and beyond. The hospital offers NHS support for Wirral, West Cheshire and Liverpool clinical commissioning groups (CCGs).

The hospital has three operating theatres (two have laminar flow) that operate six days per week, three theatre sessions per day and two sessions on Saturdays. There is also a minor ops theatre located in the outpatient's department. The hospital has capacity to accommodate 25 inpatients with ensuite single rooms and 17 day case patients and is open 24 hours per day, seven days a week.

The hospital has 16 consulting rooms across the site, including pre-op assessment rooms, breast care and outpatient consultations.

The outpatient department for adults offers a variety of specialist clinics, minor operations, physiotherapy and a private GP service.

The hospital provides day case endoscopy services and all endoscopy procedures are carried out in the main theatres by the existing theatre staff. Endoscopy procedures are undertaken typically six days per week.

The diagnostic imaging department at the hospital provides services such as ultrasound, general x-ray, digital mammography, mobile computerised tomography (CT) and on-site magnetic resonance imaging (MRI).

Other facilities include a three bedded extended recovery suite, a registered pharmacy, a specimen reception, a physiotherapy treatment area with dedicated gym and a sterile services department for the decontamination and sterilisation of theatre instruments. An independent provider British United Provident Association (BUPA) operate a health centre based within the hospital and offer private health assessments.

Spire Murrayfield Hospital has been registered with CQC since November 2010.

The hospital director has been the registered manager for the service for one year, although had been employed by the provider for twenty years in other roles.

The service is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Surgical procedures
- Family planning

Summary of this inspection

- Treatment of disease, disorder or injury
- Management of supply of blood and blood derived products

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.

We previously inspected Spire Murrayfield Hospital during September 2016. The report was published April 2017. We rated the hospital as requires improvement overall, with a rating of requires improvement for surgery and a rating of good for the outpatient and diagnostic services.

Enforcement action was taken at that time with a warning notice issued for a specific concern about the lack of assurance around the robustness of investigations of incidences of venous thromboembolisms (VTE). A further unannounced inspection took place during August 2017 and was focused on the actions taken by the provider in response to the warning notice. We found that the provider had addressed the concerns in the warning notice and had processes in place for the management of thromboembolisms.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. The inspection was unannounced. We carried out the on-site inspection on 27 to 28 April 2022.

During the inspection visit, the inspection team:

- Inspected the main ward and theatre areas, the sterile services department, the endoscopy decontamination room, the outpatients department and the diagnostic imaging department.
- Spoke with 41 staff, including the hospital director, the director of clinical services, governance manager, nurses, managers, healthcare assistants, housekeeping staff, engineering staff, consultants, the chair of the medical advisory committee and a member of the hospital's patient forum.
- Looked at the training and recruitment files for 14 staff.
- Spoke with 14 patients and relatives.
- Looked at 13 patient records.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

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

Outstanding practice

We found the following outstanding practice:

Summary of this inspection

- The service had recently developed a bespoke training and education initiative, which was completed by staff as part of the national apprenticeship programme. There were five apprentices at the hospital training to be a registered nurse, most of them were already healthcare assistants at the hospital.
- The hospital had been awarded VTE exemplar status by the national VTE exemplar centre network in January 2020 for existing track record of excellence in thrombosis care and prevention. In the past 12 months the hospital consistently achieved 100% compliance with VTE audits and their local VTE competencies had been adopted at a national level. This had supported the service in achieving the goal of VTE exemplar status which remains valid for three years.

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 **MUST** take to improve:

None.

Action the service **SHOULD** take to improve:

For surgery:

- The service should ensure that The World Health Organization (WHO) checklist has all the safety checks documented for all patients and that surgeons stay for the final sign-out step.

Diagnostic imaging:

- The service should ensure that all radiation warning signs outside diagnostic imaging rooms are working correctly at all times when the room is in use.
- The service should consider introducing individual key card access to medicine stock cupboards (as in other areas of the hospital) to improve stock control and security.
- The service should consider introducing more adapted chairs in the waiting room for patients with mobility issues or who may not be able to sit in lower chairs.
- The service should consider introducing learning disability and dementia-friendly adjustments into the department, as seen in other areas of the hospital.

Outpatients

- The service should ensure that all clinical staff complete the appropriate level of life support training.
- The service should consider introducing processes to refer patients to mental health services for support.
- The service should consider improving the management of patient records to avoid delays or missing information.






Our findings

Overview of ratings

Our ratings for this location are:

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

Diagnostic imaging

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

Are Diagnostic imaging safe?

Good 

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 received and kept up-to-date with their mandatory training.

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

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

The service had 98% completion of all mandatory training by staff for the year 2021 to 2022. This was not at 100% because a new member of staff had recently joined. The target for completion was 95%. The mandatory training year for 2022 to 2023 had begun in mid-April 2022 and overall completion rates were at 28% at the end of April 2022.

Radiologists completed mandatory training with their substantive NHS employer and provided annual confirmation of completion of this training to the hospital in line with the practising privileges policy.

For our detailed findings on mandatory training, please see the safe section in the surgery report.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse.

All clinically registered staff in the department were trained to level three in children and adult safeguarding with all other staff trained to level two. Levels one and two training were undertaken annually. Training included female genital mutilation (FGM) and child sexual exploitation.

Diagnostic imaging

There was no level four trained person in the diagnostic imaging department but there was a level four trained safeguarding lead in the hospital who was easily accessible, and staff knew how to contact them.

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

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

Staff followed safe procedures for children visiting the department although patients were asked not to bring children to the hospital unless a baby that would require feeding.

For our detailed findings on safeguarding and the hospital safeguarding lead, please see the safe section in the surgery report.

Cleanliness, infection control and hygiene

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

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. The waiting areas, examination room, diagnostic areas and changing rooms were all visibly clean and we saw completed cleaning rotas.

There were social distancing measures in place in the main waiting area to minimise infection risks and patients were asked to maintain the wearing of masks.

Staff followed infection control principles including the use of personal protective equipment (PPE). The department provided staff with personal protective equipment (PPE) such as gloves, aprons, masks and/or face visors. We observed all staff wore PPE where necessary.

The service completed monthly hand hygiene audits. The current audit showed that compliance with hand hygiene was 100%.

Staff cleaned equipment after patient contact. Radiographers completed hand hygiene before seeing a patient, wore suitable personal protective equipment and cleaned diagnostic equipment after each used. Staff were observed to be bare below the elbows.

The diagnostic department had not reported any hospital acquired infections in the previous year.

Each clinical area had a foot operated clinical waste bin, sharps bins were present which were clean, not over filled and secure.

Ultrasound probes were cleaned in line with best practice, the cleaning process was documented and audited.

Diagnostic imaging

Hand sanitiser was available for staff and patients throughout the department, staff were observed using this both before and after patient contact.

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 service had enough suitable equipment to help them to safely care for patients. The service had suitable facilities to meet the needs of patients' families. The diagnostic department was on the ground floor, this included an ultrasound scanning room, a mammography scanning room, a plain x-ray and combined fluoroscopy suite and a magnetic resonance imaging (MRI) scanner. A mobile computerised tomography (CT) scanner attended the hospital once a week and was located in the car park, next to the imaging department.

The department had plans to turn the fluoroscopy suite into a static CT scanner unit as the equipment was of an age where image quality may degrade. Patients for specialist fluoroscopy scans would be referred to another local Spire Hospital for procedures.

There were changing cubicles for patients attending for mammography and ultrasound scans.

The waiting area was spacious and had adequate seating but there was only one priority seat for patients who had recently had surgery that was raised and had a higher back but it was unclear what would happen if two or more people with mobility issues required a higher seat.

Staff carried out daily safety checks of specialist equipment. Equipment in the department was clean and well maintained and servicing contracts were in place. We saw that equipment had been serviced and the service record was in date.

Lead aprons were used when staff were carrying out fluoroscopy scans, these aprons were used to protect against radiation exposure. Staff used body and thyroid shield lead aprons. The aprons were well maintained and in good condition. We saw evidence that the aprons were scanned annually to check that they were undamaged and still offered full protection.

Local rules for radiation were displayed in the department and had been signed by all appropriate members of staff.

There was clear signage and warning lights outside controlled areas where radiation was being used, which told both staff and patients not to enter when the sign was illuminated. One of the signs was flickering but the manager told us that this had been reported and that the red "Do not enter" sign was still operational.

Staff had access to alarms in the event of an emergency.

There were pause and check signs in the control areas of each diagnostic room which reminded staff to check patient identity, correct area for scan, radiation dose and clinical justification. We observed staff checking the identity of the patient by asking full name, date of birth, address, and the areas to be scanned.

Staff disposed of clinical waste safely.

Diagnostic imaging

Emergency resuscitation equipment was available for the service on the ground floor. The diagnostic imaging department shared a resuscitation trolley with the hospital ward. The resuscitation trolley was clean, and contents were secured with a tag. The trolley was checked daily by ward staff.

Assessing and responding to patient risk

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

Staff responded promptly to any sudden deterioration in a patient's health. The department had a policy for recognising the deteriorating patient. This included escalation processes. Staff could give examples of when they had used the escalation process, this included calling the resuscitation team or resident medical officer (RMO) beginning observations and getting the resuscitation trolley. The RMO, together with the responsible consultant, would then decide to manage the patient at the hospital or authorise emergency transfer to a local NHS Trust.

A resuscitation team in the hospital was named every morning. This included a team leader, airway and compressions clinicians and a runner. Details of the team were displayed in the department at the start of each day.

The manager told us that the team in the mobile CT scanner always conducted a test call to the resus team upon arrival every week.

Staff completed risk assessments for each patient on arrival. We observed reception staff confirming patient identity when they arrived at the department, this was then checked again by radiographers before patients were scanned. Safety questionnaires were completed prior to imaging procedures taking place and patient allergies were noted on their electronic record.

Comprehensive safety questionnaires included details of any magnetic devices or implants; details of any other metal in the body; allergies and risk of pregnancy. Posters were located in the department reminding staff and patients about the need to discuss the possibility of pregnancy or risks if they already had a confirmed pregnancy.

For patients undergoing treatments using contrast agents, there was a separate safety questionnaire that also asked whether the patient had kidney function problems; were awaiting or had had a liver transplant and whether they had previously had a reaction to a contrast agent.

Staff knew about and dealt with any specific risk issues and shared key information to keep patients safe when handing over their care to others. If the radiographer noted any unexpected or significant findings from image reports these would be escalated to the treating consultant. Staff would contact the referrer by telephone and follow this up with an urgent report.

Shift changes and handovers included all necessary key information to keep patients safe. A staff huddle was held every morning, during which, any patient safety information and learning was relayed to staff, for example, during our inspection, the huddle included learning.

The service had a radiation protection supervisor. There was a service level agreement with an external company in place for a radiation protection advisor.

All staff were required to complete basic life support as part of their mandatory training. Some staff had undertaken immediate life support training and the department manager had advanced life support training.

Diagnostic imaging

There was a World Health Organisation (WHO) checklist in place in ultrasound and a WHO surgical safety checklist for non-general anaesthetic procedures.

Staffing

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

The service had enough staff to keep patients safe. The service included radiographers, and non-clinical administration staff. The service had two whole time equivalent (WTE) radiographers and six part-time radiographers. The manager adjusted staffing levels daily according to the number of clinics running and the number of patients attending. Bank staff were used to cover additional shifts if required but the service had low rates of bank nurse usage.

Managers made sure bank and agency staff had a full induction and understood the service before starting their shift. The induction programme included training on how to use the diagnostic imaging equipment. Any agency staff were used on a long-term contract so that they became familiar with the service.

The service had a low turnover of staff.

The service had low vacancy rates. There were one and a half full time equivalent vacancies for radiographers. The half a full-time equivalent was dependent on the recruitment of an additional breast radiologist of which there was a national shortage. The one whole time equivalent vacancy was to allow an increase in access and flow to the clinics and to give more time to administration and preparation.

The service had enough medical staff to keep patients safe. There were 13 radiologists supporting the service who were employed under practising privileges. They had varying specialisms, such as, muscular-skeletal (MSK); gynaecological; neurology; vascular; cardiology and breast.

For details about how the hospital checked and employed staff under practising privileges, please see the safe section of the surgery report.

Records

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

Patient notes were comprehensive, and all staff could access them easily. Patient notes were in the forms of electronic and paper. Some paper notes such as consent and referral forms were scanned and attached to the relevant electronic record. Records were stored securely.

We reviewed five patient records, all were clearly recorded with the required information for example, radiation doses, personal details, consent and confirmation that results were shared with GP, referring consultant and the patient.

Radiologists reported on images on shared electronic systems and results were securely sent to referring clinicians. The department used electronic systems such as picture archiving communication services (PACS) and radiology information software (RIS) for the storage and transfer of images. Images could be sent securely to other hospital sites if the radiologist responsible for the patients' care needed to review the image.

Diagnostic imaging

The electronic imaging systems used were password protected and all radiographic staff and radiologists had personal log in details.

Medicines

The service used systems and processes to safely prescribe and administer medicines but there was no reconciliation of medicines or records to show who had removed and how much had been removed from locked storage units.

Staff followed systems and processes when prescribing and administering medicines. Medicines used were local anaesthetic, contrast agents, cleansing agents and barium. The department did not use any controlled drugs. Staff followed current national guidance to check patients had the correct medicines.

All medicines were stored safely in locked cupboards. However, there was no stock control checks or records to show which staff had removed medicines from the cupboards or how much. We raised this with managers and were told that, in other areas of the hospital, staff accessed medicines with individual key card access that recorded who had accessed the medicine store and when and they were considering applying the same system in diagnostic imaging.

Flammable substance medicines were stored in a metal cupboard.

We found the fridge for medicines was in good working order. Room and fridge temperatures were recorded daily and were within a safe range.

Contrast medium was given by patient specific directives (PSDs). A PSD is a written instruction, signed by a prescriber for medicines to be supplied and or administered to a named patient after the prescriber has assessed the patient on an individual basis.

In the event of an emergency, the department had an adult anaphylaxis box which was in date, it was secured with a number tag by the pharmacy.

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 were aware of how to raise concerns, report incidents and near misses in line with the hospital policy. Staff reported incidents via an electronic system. The department was proactive in reporting no-harm incidents and near-misses as well as incidents where harm may have occurred.

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

Managers shared learning with their staff about never events that happened elsewhere. There had been no never events and no serious incidents reported at the hospital in the previous 12 months though learning from never events and serious incidents in other Spire hospitals were shared at staff meetings and in safety huddles.

Diagnostic imaging

The service had recently reported a “near miss” incident where a wrong side scan had been requested. Learning was shared and communicated with staff.

Staff understood the term duty of candour, which was covered in a mandatory training module for staff to complete. There was a duty of candour policy in place and staff were able to tell us what their responsibility was when something had gone wrong.

The service outlined the process of reporting a radiation incident in their radiation local rules.

Learning from incidents was shared in staff meetings and displayed on the department board. Staff informed us there was a monthly update of the hospital’s incidents and lessons that had been learnt.

Are Diagnostic imaging effective?

Inspected but not rated 

We inspected the effective domain but we do not rate this for diagnostic imaging services.

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.

Guidance from the Royal College of Radiologists, the College of Radiographers and NICE were available to staff via the intranet.

The service provided care and treatment based on national guidance including the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). Policies were aligned with and referenced the Ionising Radiation Regulations 2017. The Ionising Radiation Regulations 2017 are regulations concerned with the protection against exposure to ionising radiation as a result of work activities. The radiation safety policy and local rules for radiation safety were up to date and were available to staff both as a paper copy or electronically.

We observed that all local rules were signed and dated by staff as being understood, within the twelve months prior to our inspection. Imaging risk assessments were completed, and we saw that pathways were in place for certain conditions such as; the breast ‘one stop clinic’. Local rules were in each diagnostic room and had been signed by each member of staff. Managers checked that staff followed these.

The diagnostic department used the World Health Organisation (WHO) surgical safety checklist when carrying out invasive procedures.

The corporate provider Spire Healthcare held a national steering group for radiographers, which allowed for best practice to be shared across the provider and gave an opportunity to make recommendations on new guidance.

Diagnostic imaging

The corporate provider Spire Healthcare had a national lead for diagnostics who provided radiographic clinical leadership. The national lead ran the patient safety quality review inspection programme for diagnostic imaging services.

Nutrition and hydration

Staff gave patients food and drink when needed. Patients could access specialist dietary advice and support.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients living with diabetes where known, were booked in for appointments in the earliest time slots and told to bring snacks with them.

Hot and cold beverages were available to patients and staff told us that food could be provided to patients if they had been in the department for a long period of time.

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 a national clinical audit for patients from a private healthcare provider every three years so that the provider could ascertain that services provided remained valid to patient needs. Managers used information from the audits to improve care and treatment, for example, the breast clinic offered diagnostic imaging and also breast biopsies that meant that patients did not have to travel to another hospital to complete the diagnostic pathway.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time and used the results to improve patients' outcomes. The hospital had a clinical audit system. The department carried out local audits, such as WHO checklist audits; imaging documentation audits; post-examination documentation and point of care clinical audits.

There were quarterly performance reports based on audits and action plans were produced for any audits that were less than 100% compliant.

Managers shared and made sure staff understood information from the audits. Peer reviews of images had a rejection target of less than 5%. Results could be broken down to individual radiographers or specialities to identify any issues, for example, an issue had been discovered with the quality of ankle x-rays and adjustments had been made by using two radiographers to ensure that the patient was positioned to achieve the best image.

The diagnostic department used pathways and protocols for procedures that were evidence based and available on the intranet for staff.

Mammography screen images were double reported by two consultant radiologists in line with NHS Breast Screening Programme standards.

Competent staff

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

Diagnostic imaging

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service made sure staff were competent for their roles. All new staff were required to attend a corporate induction followed by a local induction. Areas covered included health and safety, infection prevention control governance and incident reporting. Staff told us they had received a thorough induction and had then shadowed staff until their competencies were completed. Staff told us they felt well supported during their induction.

Managers gave all new staff a full induction tailored to their role before they started work. Staff in the radiology department also had a role specific induction which covered areas such as clinical policies and procedures, radiation local rules and Ionising Radiation (Medical Exposure) Regulations (IR(MER)). Diagnostic radiographers had a comprehensive training in all diagnostic procedures in the department and there was a competency-based assessment in place.

The department also delivered radiation protection training to staff across the hospital as part of their induction, including MRI scanning and the reasons that the area had to be so secure.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff had all received an appraisal in the last year where they had highlighted areas for development and improvement with their manager.

Managers supported staff to develop through regular, constructive clinical supervision of their work. A competency framework was in place. This meant staff undertook training and were assessed in practice; the manager then verified that the member of staff was competent. All staff were expected to meet these competencies. Diagnostic staff had both electronic and paper files which included training certificates and competencies they had achieved.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us there were opportunities for continual professional development which was a requirement of their registration with the Health and Care Professions Council (HCPC).

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.

The service employed radiologists via practising privileges. There was a robust system in place which ensured clinicians were compliant with regards to their registration and training, any non-compliance resulted in a radiologist losing the right to work at the hospital until rectified.

Please see the surgery report for full details of practising privileges.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Team meetings were held monthly to discuss issues, provide peer support and share learning. The days and times of the meetings were varied to give part time staff an opportunity to attend.

Multidisciplinary working

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

Diagnostic imaging

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. There was a weekly multidisciplinary meeting for breast patients that involved the lead mammographer; breast care nurse; consultant breast radiologist; consultant breast surgeon and a histopathologist. They discussed all breast cases.

Patients could see all the health professionals involved in their care at one-stop clinics. The breast clinic was a one-stop clinic so that patients met, and were examined by the consultant radiologist, before receiving a mammogram in one place. This avoided the need for patients to dress and undress and move to different areas of the hospital.

Staff worked across health care disciplines and with other providers when required to care for patients.

We observed staff working well together as a team, the department had a positive and respectful atmosphere.

Staff told us they believed there was very good lines of communication within the department. Important messages were shared each morning.

Seven-day services

Key services were available to support timely patient care.

Staff could call for support from doctors and other disciplines.

The department was open for six days a week. This included each weekday and Saturday mornings. The service sometimes provided an MRI clinic on Saturday mornings but had found that it was more convenient for patients if they provided an evening clinic during the week.

There was an on-call service out of hours in the event that any radiography was required urgently by the hospital ward.

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. There was a health promotion noticeboard in the waiting area that contained information about smoking cessation; information about endometriosis; breast cancer care; caring for dementia and the mental health “talking about it” campaign. There were laminated leaflets that patients could ask for a paper copy of at the reception desk.

Staff assessed each patient’s health at every appointment and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care and knew how to access the policy on the Mental Capacity Act.

Diagnostic imaging

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The process for patient consent was detailed in a corporate consent policy. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We observed staff obtaining verbal consent from patients before carrying out a scan, staff asked patients if they knew why they were having the scan, explained the procedure and confirmed with the patient if they were happy to have the scan.

Patients attending for an MRI scan were required to complete a safety checklist and give written consent prior to entering the scanning area.

Staff made sure patients consented to treatment based on all the information available.

When patients could not give consent, staff followed policy to ensure decisions were made in their best interest, taking into account patients' wishes, culture and traditions. Staff were aware of the hospital's mental capacity policy and could explain what would happen if a person did not have the capacity to consent to any imaging procedure. They told us they would not continue with the scan but would seek further guidance from the referring doctor.

Staff told us that patients who lacked full capacity were generally accompanied by a relative or carer.

Staff clearly recorded consent in the patients' records. We reviewed five sets of patient notes and saw that these all had consent signed by the patient.

Staff received and kept up to date with training in the Mental Capacity Act and deprivation of liberty safeguards.

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

For patients who could not speak English there was an interpreting service available that could be used to help with the consent process.

Are Diagnostic imaging caring?

Good 

We rated caring as good.

Compassionate care

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

Patients said staff treated them well and with kindness. We spoke to two patients and one relative who all said that they had received excellent care and had been treated kindly and with compassion. One patient said that the care they had received could not have been better.

Diagnostic imaging

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. Staff introduced themselves to patients and took time to ask how they were feeling. Staff asked patients how they felt about the imaging procedure and if they had any questions. We saw that reception staff asked patients how they had got on when they left their scan and needed to book a follow-up appointment. They were kind, sensitive and caring when speaking to patients on the telephone.

Staff clearly explained the diagnostic procedure and the time it would take to the patient. We witnessed staff interacting with patients before and throughout their procedure. Staff gave patients positive feedback during the imaging procedure where appropriate and continued to ask how the patient was doing. Patients were reminded to tell staff if they wanted the procedure to stop at any time.

Staff maintained privacy and dignity by ensuring blinds and doors were closed when patients entered the room.

Chaperones were available to support patients during procedures if needed.

Staff followed policy to keep patient care and treatment confidential.

Emotional support

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

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

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. There was a quiet room available where patients could wait for their scan for those patients that needed it.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

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 maintained constant interaction with patients throughout their scans, they talked patients through the procedure and went at a pace that suited the patient. Patients who may need more time for scans due to complexities such as mobility issues or pain were highlighted during the booking process so that additional time could be added to their appointment.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff asked patients if they felt they would be able to maintain a certain position for the length of time needed while undergoing a scan.

There was a one stop breast clinic and staff told us how they supported patients who were attending the clinic and awaiting results.

Patients told us that staff were very reassuring. Patients told us that everything had been explained to them very well and they were well informed about how long they would have to wait for any results.

Diagnostic imaging

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

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff could explain what they would do if they recognised a patient who may need additional support to understand and be involved in their care.

Staff talked with patients, families and carers in a way they could understand.

Staff supported patients to make informed decisions about their care.

There was a range of imaging and diagnostic information on the services website which was available to patients. This information explained why someone might need an x ray, who would do it and the procedure.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There were posters in the waiting area which highlighted to patients how to give feedback.

Patients gave positive feedback about the service. We reviewed the patient feedback comments provided to the service and saw that they were extremely positive. In March 2022, the patient feedback rated the service as good or very good in 98% of the feedback. The manager told us that from January to June 2021, the department had been the third best in the Spire group for positive feedback.

Feedback comments were passed on to staff to reassure them that the patients had a good experience. Negative comments were analysed and used to make improvements to the department, for example, a patient had felt the scrubs they were given to wear during an MRI scan were too small and they did not feel that their dignity was maintained so the department improved the range of available sizes for patients.

Are Diagnostic imaging responsive?

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. 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 department offered a range of diagnostic services to both self-paying, privately insured and NHS patients.

Diagnostic imaging

The service minimised the number of times patients needed to attend the hospital by ensuring patients had access to the required staff and tests on one occasion. The service offered a one-stop breast clinic in one department so that patients received an outpatients examination and mammogram and biopsy on the same day and in the same place.

Patients attending outpatient appointments who required an x-ray were sent to the department where they were processed as a priority.

Facilities and premises were appropriate for the services being delivered. The car park was in front of the hospital which had parking spaces for people with disabilities. However, the hospital was not easily accessible by public transport. There was a large waiting area in the diagnostic department. There were hot and cold beverages available in the waiting area. The waiting area was on the ground floor and accessible to wheelchair users.

Managers ensured that patients who did not attend appointments were contacted. The department monitored patients who did not attend for treatment, the levels were low. Patients would be contacted and asked if they wanted to book a new appointment.

The department offered late evening and weekend appointments to accommodate for patients who could not make weekday appointments, for patients who needed an urgent scan the best effort was made to give the patient a scan on the day they were referred.

Meeting people's individual needs

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

The department displayed a poster about accessible information standards and advised patients or carers to speak to a member of staff about this. The poster stated that this was "to make sure that people who have a disability, impairment or sensory loss are given information they can easily read or understand". Information was available to patients in large print; sign language; easy read; text to speech; via a hearing loop; by SMS; braille or via email.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Patients with complex needs were provided with increased appointment times to allow staff time to provide additional support and these could be at the beginning or end of a clinic.

Staff gave examples of patients with learning disabilities or living with dementia who had attended for diagnostic imaging. Patients had been accompanied by carers for support.

The department was not designed to meet the need of patients living with dementia. There were no dementia friendly or learning disability adjustments in the department, such as signage or clocks as were evident in other areas of the hospital.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Interpreter and translation services were available. Posters were displayed in languages other than English.

Posters were displayed in the waiting area and changing rooms which explained what an x-ray was and why they are used.

Diagnostic imaging

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Patient appointments were booked by the administrative team, who assessed patients' individual needs and scheduled an appointment with adequate time.

Managers worked to keep the number of cancelled appointments to a minimum, managers made sure they were rearranged as soon as possible and within national targets and guidance.

If a patient's appointment was cancelled, administrative staff would call the patient on the same day and rebook an alternative appointment as soon as possible.

The department had targets for reporting times for images. The target was to produce a report within five working days. The reporting time for all types of diagnostic imaging from January to March 2022 was an average of less than a day. These figures and targets were displayed in patient areas. Consultants were able to request urgent reporting if required.

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. Patients we spoke with knew how to raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Posters in the waiting area directed patients on how to make a complaint.

Managers investigated complaints and identified themes. The diagnostic manager told us that the service took complaints seriously and tried to resolve complaints at the point of care. They told us that patients were always offered a chance to report their complaints formally if they remained unhappy.

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

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

Staff could give examples of how they used patient feedback to improve daily practice. Managers told us about examples where patient feedback had been used to improve practice.

Are Diagnostic imaging well-led?

We rated well-led as good.

Diagnostic imaging

Leadership

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

For detailed findings on leadership, please see the well-led section of the surgery report.

The service had a clear leadership structure. There was a radiology manager for the department who also acted as the radiation protection supervisor. They oversaw the day to day running of the service. They were an experienced radiologist and had worked in the hospital for seven years. They also managed the physiotherapy unit that was located in the same area.

Staff told us that they felt well-supported by the departmental manager and had opportunities to learn and progress. They also told us that senior leaders were very visible in the hospital, knew all the staff and they encouraged staff to speak to them about any issues.

The manager told us that they had undertaken a course in management fundamentals and there was also an apprenticeship programme in management available for managers to undertake.

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.

For detailed finding on vision and strategy, please see the well-led section of the surgery report.

The diagnostic imaging service had a local strategy for 2021-2022. The elements in the strategy were: to achieve a good or outstanding CQC rating; safe care in a COVID world; strengthen data driven clinical improvement performance and be known for clinical quality and excellence.

The strategy action plan clearly showed the actions required to achieve the strategy elements, an action lead and a completion date.

Culture

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

For detailed findings on culture, please see the well-led section of the surgery report.

Staff that we spoke with were motivated and positive about their work and told us that they felt supported and valued. They felt that they worked well together as a team to provide good patient-centred care.

A member of staff who had only worked there for a few months told us that the leadership were fantastic, and they had been fully supported by their colleagues and helped to settle in with an excellent induction.

Diagnostic imaging

The last staff survey showed that, in the department, 100% of respondents were proud to work for the organisation.

Staff told us that senior managers had an open-door culture and encouraged staff to raise concerns. There were freedom to speak up champions in the hospital and staff knew who they were.

Governance

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

There was a clear governance structure for the department.

The manager attended a monthly clinical effectiveness meeting. Issues arising from this meeting fed into the clinical governance meeting that was held every three months to review policies and procedures, discuss incidents and complaints and any safety issues.

Heads of departments held monthly meetings with set agendas.

There were monthly staff team meetings within the department. This meeting had a standard agenda that included a review of actions; business matters; departmental updates; continued professional development updates; learning; regulatory updates and people issues. We reviewed the minutes from the last team meeting and found them to be well-ordered and comprehensive.

The hospital had a medical advisory committee (MAC) which was made up of consultants who worked at the hospital and included radiologists.

Annual Radiation Protection Committee meetings were established and attended by the radiation protection advisor, hospital director, diagnostic imaging manager as the radiation protection supervisor, clinical governance lead and director of clinical services. The last meeting had been held in August 2021 and an annual action plan had been developed.

For our detailed findings on governance, please see the well-led section of the surgery report.

Management of risk, issues and performance

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

There was a departmental risk register in place that was categorised into various risk assessment groups: clinical risks; general risks; non-clinical risks; MRI risks; students; visitors and radiation risks. Risks were reviewed monthly and had a risk owner and there were mitigating actions to minimise the risk against each risk.

A risk scoring system was used to identify and escalate key risks to the hospital risk register. Key risks were reviewed at monthly departmental meetings and clinical governance meetings.

Diagnostic imaging

The key risks within diagnostic imaging were the lack of a static CT scanner; the risks associated with room one that housed fluoroscopy and had aging equipment and the risk of a patient reaction to the contrast agent.

The first two risks were in the top five hospital risks.

The diagnostic imaging manager had recently attended a risk management workshop.

The service managed performance with the aid of a performance dashboard. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through routine team meetings, safety huddles, performance dashboards and newsletters.

The performance dashboard covered key indicators such as average time from referral to appointment and average time from appointment to report. Most patients received an appointment within a week for MRI appointments with many sooner.

For our detailed findings on management of risk, issues and performance, please see the well-led section of the surgery report.

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.

There were systems in place for the safe storage, circulation and management of electronic and paper-based records such as patient records, performance reports, audit records and meeting minutes.

Staff completed information governance training as part of their annual mandatory training. Records showed 100% of staff in the diagnostic imaging services had completed this training.

The manager reported there had been no data breaches that were reportable to the Information Commissioner's Office (ICO).

Electronic systems (such as to store records and manage patient appointments) required password access. Diagnostic scan results, reports and images were stored electronically and could be accessed by staff in other parts of the hospital, such as during routine outpatient consultations.

Staff could access information such as policies and procedures in paper and electronic format. The policies we looked at were version-controlled, up to date and had periodic review dates.

For our detailed findings on information management, please see the well-led section of the 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.

Diagnostic imaging

Staff felt well informed about what was going on within the hospital and hospital group and received any updates daily at morning huddles. There was a monthly staff newsletter.

Representatives from the diagnostic imaging department were part of a staff engagement circle that met regularly to talk about interdepartmental issues and events.

The hospital staff partook in charity fund raising and social events.

There were mental health first aiders for staff.

The service engaged well with patients to gather feedback and make improvements. There was a portal for patients to give feedback on care and lived experiences and the service held patient satisfaction meetings. The portal allowed feedback specific to diagnostic imaging to be filtered out.

Feedback from complaints was shared regularly with staff and managers.

Staff could give examples of changes that had been made based on patient feedback.

For our detailed findings on engagement, please see the well-led section of the surgery report.

Learning, continuous improvement and innovation

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






The diagnostic imaging department had a commitment to continuous improvement. They had plans in place to replace aging equipment with a new static CT scanner. This would allow CT scans to take place over six days a week, rather than just on one day when the mobile CT scanner was on site.

The staff were proud of introducing the rapid access breast clinic to the department.

Managers encouraged innovation by staff. The radiographer in the MRI scanner area was the lead trainer in the department and had developed training competencies for staff interested in or training to work in MRI scanning. We reviewed the files and found them to be comprehensive with scenario-based training. Staff were given an opportunity to carry out a number of scans on different body parts under supervision until their competencies could be signed off.

The documents had been shared with the national clinical specialist for imaging in the Spire Hospital Group and were made available across the group for other sites to use.

Medical care (Including older people's care)

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

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

Good 

We rated safe as good.

Mandatory training

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

Mandatory training was delivered through e-learning modules with some face to face training modules. Managers monitored mandatory training on a monthly basis and alerted staff when they needed to update their training. Staff were given the opportunity to complete mandatory training during work time and told us it was easily accessible and they were given sufficient time and support to complete it.

Mandatory training covered key topics such as fire safety, health and safety, infection prevention and control, compassion in practice, information governance, data protection, equality and diversity, manual handling and adult and children's safeguarding training.

Endoscopy staff compliance figures were included in the theatre staff data and was not reported separately. Compliance for theatre staff ranged between 96% and 100% which showed most theatre staff had completed mandatory training and achieved the hospital's training completion target of 95%.

For our detailed findings, see the surgery report.

Safeguarding

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

Staff we spoke with told us that they undertook safeguarding training. Endoscopy staff compliance figures were included in the theatre staff data and was not reported separately. Data for the current training year showed 100% of theatre staff had completed adult safeguarding (level two or three) training and 100% of theatre staff had completed safeguarding children (level two or three) training. This showed that all endoscopy staff had completed safeguarding training and the hospital's training completion target of 95% had been achieved.

Medical care (Including older people's care)

For our detailed findings, see the surgery report.

Cleanliness, infection control and hygiene

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

All endoscopy procedures were carried out in the main theatres by the existing theatre staff. On admission patients waited on the ward as day cases. There were separate bays for males and females.

The hospital completed audits for cleanliness and provided compliance data for surgery (this included endoscopy). Compliance was 100% from February 2022 to April 2022 and 100% compliant for the same period for hand hygiene.

The service had defined roles, responsibilities and a designated area for decontamination of endoscopic equipment. There were four staff trained in sterile services, this included the endoscopy lead and two new starters were being trained. They were accountable to the theatre manager and sterile service lead.

The endoscopy areas were visibly clean and tidy.

There was a process in place to track and trace the decontamination journey of all endoscopes and this was recorded electronically on a specialised software programme. The endoscopy lead told us that after an endoscope had been used staff performed a bedside clean before the endoscope went into the decontamination room.

The electronic system showed the endoscope had been cleaned and provided two printed tickets of this before it was moved to the drying cabinet. One ticket was kept in patient notes and the second ticket stayed with the endoscope and would trace where it had been previously. Clean endoscopes stayed in the drying cabinet for up to ten days. An alarm system alerted staff when the ten days was up and a light changed from green to red. All endoscopes were used within three hours after they were removed from the dryer.

The sterilisation had an expiry date on the tickets and if not used within that time frame had to be reprocessed before use.

The hospital was compliant with Health Technical Memorandum (HTM 01-06): management and decontamination of flexible endoscopes. The decontamination manager told us that the initial bedside endoscope clean was completed by theatre staff immediately after the completion of the endoscopic procedure. Used endoscopes were sealed in a red bag and placed in a trolley ready for removal to the decontamination room. Staff told us they manually flushed the endoscopes and performed a leak test in the designated area prior to using the washer disinfectant. This was in line with best practice guidance. Protein tests were also performed and clean endoscopes were placed in a green bag ready for use.

Cleaning checklists were completed daily and displayed on the wall. These were completed, up-to-date and demonstrated that all areas were cleaned as per the required daily and weekly cleaning schedules. The endoscopy lead told us that theatres underwent periodic deep cleaning every six months and certificates of this were displayed in the staff office.

Medical device risk assessments and weekly water tests were overseen by the hospital engineering manager.

Medical care (Including older people's care)

Water samples from the washing machine were taken weekly by the hospital engineering manager which were sent to an external laboratory for testing to ensure no microorganisms were present.

The engineering administrator showed us the electronic system used to monitor water testing. This showed the hospital was fully compliant with testing.

Staff followed infection control principles including the use of enhanced personal protective equipment (PPE) for the decontamination of endoscopy equipment. The decontamination lead told us that all staff had to be compliant with the PPE. Staff wore long aprons and head visors, they changed their shoes when handling used endoscopes, they wore white hats when in the decontamination area and blue hats in clean areas.

For our detailed findings, see 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. Staff managed clinical waste well.

The maintenance and use of equipment kept people safe. Maintenance contracts with manufacturers of the equipment were in place for annual testing and three services a year. Weekly testing was done by the designated staff for endoscopy decontamination equipment. Checks for leaks and endoscopy wear and tear were carried out during the hand washing process.

The endoscopy lead told us that the hospital had external contracts for maintenance of equipment. The main contract was with the equipment manufacturer who provided engineers to come on site and check for issues when required. The external engineers checked the endoscopes annually, completed health checks on all the endoscopes and if needed sent them for repair.

The hospital engineering manager completed weekly tests of the endoscopy decontamination equipment and the endoscopy lead then checked and approved them. There were processes in place for the validation of test reports for endoscopy equipment which was validated by an independent authorising engineer in decontamination.

The design of the endoscopy environment followed national guidance. The endoscopy lead told us that the department had a pass through washing machine without a separate wall. There was a sign posted door specifically for used endoscopes and clean endoscopes came out of a separate door. The one way system meant there was a clear flow of dirty to clean instrumentation within the single decontamination room and a system in place to minimise cross contamination.

The service had enough suitable endoscopy equipment to safely care for patients and allow for effective decontamination processes. This included two scope washer-disinfector units and a drying cabinet.

The service undertook assessments and reviews of their activities under the Control of Substances Hazardous to Health Regulations 2002 (COSHH) and had a COSHH/risk lead. Staff we spoke with were aware of COSHH and told us that documentation and manuals were easily accessible both electronically and in the COSHH file which was updated regularly. The department had a lockable COSHH cupboard in the decontamination room and we observed a spillage kit for chemicals.

Medical care (Including older people's care)

The endoscopy lead told us that the decontamination room was not locked but only theatre staff have access because all connecting doors to the room are security coded. Only designated staff knew the code to gain access.

The decontamination lead was responsible for instrument repair, procurement and loan instruments. However, they told us that the decontamination of instruments took priority.

For our detailed findings, see the surgery report.

Assessing and responding to patient risk.

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

Staff used national early warning score systems (NEWS2), a nationally recognised tool, to identify deteriorating patients. The endoscopy lead told us that most patients had sedation and remained in the recovery area before being assessed as safe to return to the ward.

There were clear pre-assessment processes for patient suitability to undergo an endoscopy at the hospital. Screening for allergies, COVID-19 and MRSA were undertaken in advance of coming into hospital.

All patients received an initial pre-operative telephone call and could attend the hospital for a pre-operative assessment if required. Patients who met certain criteria following completion of a medical questionnaire did not require further pre-operative risk assessments or being seen before their endoscopy procedure.

A full pre-operative assessment was required for patients with complex medical conditions to ensure suitability for treatment and management. Where increased risk was identified this was escalated to the consultant to assess the risk and make an appropriate treatment plan.

Medications were not routinely stopped for day case patients undergoing endoscopy. The endoscopy lead told us that typically patients took their medications prior to arrival then ward or theatre staff liaised with pharmacy when required. Anaesthetists or consultants prescribed any new medicines and all patients had prescription charts in their notes.

For our detailed findings, see the 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.

Information received from the provider showed endoscopy staff were included in theatre numbers.

There was an endoscopy lead/theatre co-ordinator and a decontamination lead.

Staff involved in endoscopy procedures included seven members of staff, six consultants and four decontamination staff.

For our detailed findings, see the surgery report.

Medical care (Including older people's care)

Records

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

Patient notes were comprehensive, and all staff could access them easily.

Both electronic and paper records were stored securely with secure passwords for online systems and locked cabinets for paper records.

Patient records for endoscopy included full case notes, care pathways specific for endoscopy, team briefs and safer surgery checklists.

Audit data provided for endoscopy patient records between February 2022 to April 2022 was 100% compliant.

For our detailed findings, see the surgery report.

Medicines

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

Medicines used for endoscopy services were managed by the surgical ward and theatre teams.

For our detailed findings, see the surgery report.

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 received feedback from investigation of incidents, both internal and external to the service and staff met to discuss the feedback and look at improvements.

There had been one reported incident in the last 12 months related to an endoscopy procedure which involved a diathermy machine. The endoscopy lead gave an example of the learning related to this incident. They explained that staff now reported an audible click when the machine was connected and introduced verbal statements to the consultant such as 'it's set up'. The hospital also bought a new diathermy machine with additional features and it was the same model used by consultants at their host trusts.

The service used a surgical safety checklist for endoscopy. Combined data for surgery and endoscopy was reviewed from the provider and showed 100% compliance.

For our detailed findings, see the surgery report.

Medical care (Including older people's care)

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

Good 

We rated effective 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.

All policies, standard operating procedures and guidelines were corporate but bespoke to the hospital.

For our detailed findings, see the surgery report.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

For our detailed findings, see the surgery report.

Pain relief

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

Pain comfort scores were based on the Gloucester comfort scale with zero representing no pain to four indicating severe pain. The hospital provided data from four patient records that evidenced pain comfort scores had been recorded for all four patients.

For our detailed findings, see the 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 monitored patient outcomes and data showed positive results. For example, between January 2022 and March 2022 94% of patients said they were given information regarding their procedure and 100% of patients reported no delays. Also, 90% of patients were satisfied with the consent process and 80% of patients stated the comfort level was acceptable during procedure.

The service was not joint advisory group (JAG) accredited for endoscopy but was working towards JAG accreditation. The endoscopy lead told us they had purchased new equipment which included a diathermy machine.

For our detailed findings, see the surgery report.

Medical care (Including older people's care)

Competent staff

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

Managers made sure staff received any specialist training for their role which was evidenced in additional data received from the provider. The decontamination lead told us that all staff were up to date with their competencies. All decontamination staff were trained and had demonstrable competencies for their roles. We saw in staff records appropriate training was undertaken and staff signed off as competent.

The decontamination lead was suitably qualified with a qualification from the Institute of Decontamination Sciences and encouraged staff to complete further training on sterilisation and decontamination.

There was evidence of Control of Substances Hazardous to Health (COSHH) annual training for all decontamination staff in the competency files we reviewed.

The decontamination lead told us that when staff were not undertaking the decontamination of endoscopes they were still involved with the sterile services department (SSD) for other equipment and devices.

Staff completed appraisals every six months and had one-to-one supervision. The hospital provided data that showed 100% of staff had received an appraisal.

For our detailed findings, see the surgery report.

Multidisciplinary working

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

The endoscopy lead told us that the endoscopy team worked well with the surgical and theatre staff, they were mutually supportive and the communication was really good.

Staff attended an endoscopy user group every two months which included the endoscopy lead, the regulatory compliance lead, director of clinical services, a consultant general surgeon, pharmacy staff, engineering staff and pre-operative staff. They discussed equipment, engineering issues, maintenance contracts, consultants performance, incidents and feedback from patients.

For our detailed findings, see the surgery report.

Seven-day services

Key services were not available seven days a week.

Endoscopy sessions were being undertaken six days a week between 8am-8pm weekdays and 8am to 4pm on Saturdays. The decontamination lead was on-call if endoscopy procedures were required out of hours.

For our detailed findings, see the surgery report.

Medical care (Including older people's care)

Health promotion

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

For our detailed findings, see the surgery report.

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.

Staff recorded consent in the patients' records and used the same consent forms as the surgery department.

For our detailed findings, see the surgery report.

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

We rated caring as good.

Compassionate care

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

The friends and family test is a survey that measures patients' experience of the service they have received. The majority of patients were positive about their experience and recommended the hospital's surgical services to friends and family. The test data between October 2021 and March 2022 showed the average monthly responses for patients reporting a good or very good experience across the surgical services, including endoscopy, ranged between 91% and 98%. The average monthly response rate ranged between 65 and 100 patients per month during this period.

Feedback from the patient satisfaction survey between January 2022 and March 2022 showed that 98% of patients felt that staff were attentive.

For our detailed findings, see the surgery report.

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. Patients could be referred for access to counselling and psychological support if required.

For our detailed findings, see the surgery report.

Medical care (Including older people's care)

Understanding and involvement of patients and those close to them

For our detailed findings, see the surgery report.

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

Good 

We rated responsive 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.

The endoscopy services were provided in the surgical ward and theatre areas. The hospital carried out endoscopy procedures for both private and NHS funded patients.

For our detailed findings, see the surgery report.

Meeting people's individual needs

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

The endoscopy department had a small size scope available to use on small patients and staff used latex free gloves when handling the endoscopes to protect patients who may be latex sensitive.

For our detailed findings, see the surgery report.

Access and flow

People could access the service when they needed it and received the right care promptly. Patient length of stay and discharge processes were effectively planned and organised.

The provider did not have specific data for endoscopy waiting times against national requirements as they were included in the surgical wait times.

The endoscopy lead told us that they managed patient waiting times for endoscopy by prioritising clinically first, and then chronologically. Occasionally a consultant would request that a patient be fast tracked and seen immediately if they were high risk.

Cancelled endoscopy appointments were rebooked on the next available list within 28 days. When appointments were cancelled a process was in place to call the patient the same day to rebook an alternative appointment.

For our detailed findings, see the surgery report.

Medical care (Including older people's care)

Learning from complaints and concerns

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

The service clearly displayed information about how to raise a concern in patient areas. Patients, relatives and carers knew how to complain or raise concerns.

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

For our detailed findings, see the surgery report.

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

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.

The service had an endoscopy lead, a general team leader for theatres who undertook endoscopy procedures, an anaesthetist recovery team leader, a surgical safety guardian and a sterile service lead in addition to endoscopy staff.

Staff told us that senior management had improved the service over the past few years and were very approachable, supportive and always positive. They described the hospital as a great place to work.

For our detailed findings, see the surgery report

Vision and Strategy

The provider had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy included the goal of achieving joint advisory group (JAG) accreditation.

The goal to achieve national accreditation for endoscopy was on the clinical strategy for 2021-2023. The hospital aimed to provide patients with assurance that their services are of the highest standard. Staff planned to work towards the goal of accreditation by participating in training and inspections by JAG.

For our detailed findings, see the 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 patients, their families and staff could raise concerns without fear.

Medical care (Including older people's care)

The staff we spoke with were positive about working in the surgical and endoscopy services. They told us there was a friendly and supportive culture throughout the hospital across all staff levels. Staff said that senior management were visible, approachable and had an 'open door' philosophy.

For our detailed findings, see the surgery report.

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.

For our detailed findings, see the surgery report.

Management of risk, issues and performance

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

The decontamination lead told us that the biggest issue for the department was lack of storage space and a small autoclave room.

For our detailed findings, see the surgery report.

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.

For our detailed findings, see the surgery report.

Engagement

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






For our detailed findings, see the surgery report.

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.

For our detailed findings, see the surgery report.

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

Are Surgery safe?

Good 

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

Mandatory training

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

Mandatory training was delivered through e-learning modules with some face to face training modules. Managers monitored mandatory training on a monthly basis and alerted staff when they needed to update their training.

The mandatory training was completed on a rolling monthly basis and the hospital's annual target for the current training year was to achieve at least 95% training compliance for all staff by the end of March 2023. The hospital reported they had achieved the 95% compliance target for all mandatory training modules at the end of the previous training year (2021/2022).

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training covered key topics such as fire safety, health and safety, infection prevention and control, compassion in practice, information governance, data protection, equality and diversity, manual handling and adult and children's safeguarding training.

Mandatory training compliance for the current year was reported for all the individual training modules. Surgery staff was broken down into pre-assessment, theatre staff, ward staff and ward admin. Compliance for theatre staff ranged between 96% and 100% and ward staff ranged between 93% and 100% at the time of our inspection.

This showed most theatre staff had completed mandatory training but the hospital's training completion target of 95% had not yet been achieved by all ward staff for all training modules. These modules were quality improvement, anti-bribery and compassion in practice. Remaining staff had until March 2023 to complete their training as the new training year had started in April.

The end of year target of 95% compliance had already been achieved for both theatre and ward staff for some training modules such as data protection, equality and diversity, infection prevention and health and safety.

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The ward and theatre staff also completed additional role-specific training in addition to the core mandatory training. This included topics such as blood borne viruses, blood transfusion, controlled drugs, duty of candour, medical gases and the mental capacity act.

The staff we spoke with told us mandatory training was accessible and they were given enough time and support to complete their mandatory training.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. All staff were required to complete a minimum of level two safeguarding training for adults and children annually and a number of registered clinical staff completed level three training. Although the hospital did not provide services for children and young people, several staff had completed a more advanced level of training.

The hospital provided data that showed surgery staff compliance was 99% for both safeguarding adults and safeguarding children training at the end of the previous training year (2021/2022).

Records for the current training year showed 100% of theatre staff and 98% of ward staff had completed adult safeguarding (level two or three) training and 100% of theatre staff and 98% of ward staff had completed safeguarding children (level two or three) training.

This showed most staff across the surgical services had completed safeguarding training and the hospital's training completion target of 95% had been achieved.

Two staff who had not yet completed the training were new starters in 2022 and consisted of one administrator and one healthcare assistant.

The safeguarding training also included female genital mutilation and prevent (counter-terrorism strategy) training.

The director of clinical services was the safeguarding lead and had completed adult and children's safeguarding (level four) training along with other staff from the safeguarding lead team. At the time of inspection five staff had completed the level four training. This included the hospital director, director of clinical services, governance manager, ward manager and the regulatory compliance lead.

The director of clinical services told us that safeguarding was covered at induction and staff were given real life examples from the hospital. They described a good working relationship with the clinical commissioning group (CCG) safeguarding lead who provided them with clinical supervision.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service had safeguarding policies available to support staff and these could be accessed on the hospital's intranet. Staff we spoke with knew who the safeguarding leads were and could follow a visual flow chart that clearly outlined the processes to follow.

Heads of departments and the director of clinical services regularly reviewed safeguarding incidents at the monthly clinical governance committee. Senior management also discussed any safeguarding incidents at the medical advisory

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committee, the senior management team meetings and CCG meetings. The service reported five safeguarding incidents during the past 12 months. The safeguarding lead told us that incidents were immediately reported to the adult safeguarding team within the local social services department, they were investigated locally and shared with the patient's GP when necessary.

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.

Staff received mandatory training in infection prevention and control (IPC) and there were infection prevention and control policies and procedures in place which provided further guidance for staff.

Patients underwent methicillin-resistant staphylococcus aureus (MRSA) screening and pre-admission checks for other infection risks, such as Clostridium difficile (C. difficile), prior to admission for surgery. We saw evidence of this in the patient records we reviewed during the inspection. The hospital had not reported any healthcare-acquired infections or outbreaks during the past 12 months.

The ward manager told us that when a patient had MRSA, staff were made aware in advance and placed the correct bag in the patients' room for infectious waste. For example, striped bags were used for normal clinical waste and orange bags were used for infectious waste. Patients were prescribed treatment for MRSA which they used five days prior to admission and continued with the treatment throughout their stay.

Staff followed national guidance around managing COVID-19 risks. Staff, patients and visitors attending the hospital were required to wear personal protective equipment, such as masks and aprons. We saw there were appropriate measures in place for segregation and social distancing to minimise the risk of spread of infection. Each room in the hospital had a notice on the door to indicate the maximum number people allowed.

The ward manager told us that patients were asked their vaccination status in the pre assessment screening. Surgical patients attending the hospital were also required to carry out a COVID-19 lateral flow test two days prior to admission and again on the day of admission. Patients had to provide evidence of their test results and the hospital had spare lateral flow tests on site if patients had forgotten to take the test.

Patients identified with an infection could be isolated in single rooms in the ward areas and staff used appropriate signage to protect staff and patients if a patient had been isolated.

Staff worked effectively to prevent, identify and treat surgical site infections (SSI's). The hospital conducted surveillance of SSI's and reported 23 SSI's from May 2021 to the end of April 2022. This equated to an SSI rate of 0.26% and were across a number of specialities: Breast (four) Spinal (three) Knee (four) Hip (six) Hernia (three) Hand surgery (one) and Laparoscopy (two).

The ward and theatre areas were visibly clean and had suitable furnishings which were clean and well-maintained. The theatre environment was compliant with NHS Health building note 00-09 (HBN 00-09): infection control in the built environment. Flooring was in a good state of repair and compliant with the standard for HBN 00-10: Part A flooring.

During our inspection we saw that cleaning schedules and daily checklists were in place and up to date. Staff had clearly defined roles and responsibilities for cleaning the environment and decontaminating equipment. Theatre staff were

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responsible for cleaning following a procedure and the cleaning team did the general clean every evening including ventilation grills. Staff used alcohol wipes and chlorine-based disinfectant to clean and decontaminate surfaces and equipment. The theatres underwent periodic deep cleaning every six months with additional cleaning after any patients with infection risks. We saw 'I am clean stickers' for equipment that had been cleaned.

The hospital had an on-site sterile services department (SSD) for the decontamination and sterilisation of reusable medical equipment and devices. The SSD was accredited to the international standard ISO 13485:2016 and the director of clinical services told us that the accreditation certificate was displayed in the autoclave room. The most recent ISO 13485 standards accreditation was achieved April 2019 and was valid until November 2022. There were no recommendations from the inspection.

There was a programme in place to routinely flush all water outlets weekly to minimise the risk of Legionella and we saw checklists were completed to document flushing activities. The engineering administrator told us the service scored 29 out of 32 in the most recent Legionella audit. The report noted recommendations and remedial actions for the provider to take and these had all been completed at the time of inspection.

All the staff we observed wore suitable personal protective equipment, such masks, visors, gloves and aprons while delivering care. We observed staff following hand hygiene and 'bare below the elbow' guidance appropriately. Visitors were encouraged to wash their hands at reception and areas throughout the hospital.

We saw evidence that infection control audits were undertaken quarterly by the deputy ward manager. The audits included checks of hand hygiene, environment, mattresses, catheters, cannulas and taking blood.

The service performed well for cleanliness and hand hygiene. Data audits for cleanliness showed that surgery was 100% compliant from February 2022 to April 2022 and 100% compliant for the same period for hand hygiene. The hospital consistently scored 100% for these audits over the previous 12 months.

The service had an IPC lead who oversaw infection control processes and provided support for staff. They conveyed any infection incidents, oversaw audits, training and changes to policies and national guidance and shared any new concerns at the daily hospital huddle. Each department within the hospital had an infection control link nurse in place to provide support and guidance for staff.

There was a hospital-wide infection prevention and control committee, which held meetings every three months to review infection control processes. The committee was attended by a range of staff including the director of infection prevention and control, the hospital director, sterile services lead, hospital engineer, all heads of departments and a microbiologist.

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 surgical ward and theatre areas we visited were well maintained and provided a suitable environment for treating patients. All patient rooms had call bells within reach and auxiliary outputs (such as oxygen and medical gases).

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The theatres had effective systems for the storage and management of surgical implants and surgical procedure packs. The implants we looked at in storage were found to be in date and showed effective stock rotation. We observed a surgeon check all implants and theatre staff checked equipment and instruments prior to surgery. The storeroom looked visibly clean and tidy with no items stored on the floor.

Access to the surgical wards was secure and the theatre rooms could only be accessed via a key card.

All the pieces of equipment we saw were clean, well maintained and had service stickers displayed showing they were within the service, calibration and electrical safety test due dates. The engineering manager told us that some equipment was tested annually and others every six months. Portable appliance testing (PAT) was done annually during a weekend and every electrical item was tested.

The service had enough suitable equipment to help safely care for patients. The ward manager told us that the equipment lead ensured machines were checked monthly, audited and calibrated.

The maintenance schedule was monitored electronically and listed clearly when equipment was due for servicing. Equipment servicing was carried out by external contractors and overseen by the engineering manager and engineering administrator. Any faulty equipment or user error was reported as an incident and learning was shared with all staff.

Engineering staff showed us the computer software and a spreadsheet that clearly demonstrated what equipment was due for servicing the following month. This included vital signs machines, electrocardiogram machines, theatre equipment, beds, trolleys and hoists. They told us that staff checked electrocardiogram machines every time they were used and reported any issues electronically. The engineering manager would then remove it from use to be repaired.

Single-use, sterile instruments and consumable items were stored appropriately, and staff disposed of clinical waste safely.

There were arrangements in place for the handling, storage and disposal of clinical waste. We observed that the surgery department was compliant with health technical memorandum 07-01 (HTM 07-01): safe management and disposal of healthcare waste. Staff used sticker labels to place on clinical waste bags, indicating the area and date the label was applied. All sharp bins were found to be secure, signed, dated and not over filled.

Staff carried out daily safety checks of specialist equipment. Emergency resuscitation equipment was available in all the areas we inspected and we saw that daily and weekly equipment check logs were complete and up to date in those areas. All the emergency resuscitation trolleys we saw were tagged to minimise the risk that items could be tampered with. Resuscitation trolley audits over the past three months showed resuscitation trolley compliance was 99% in the ward and 100% for theatres, indicating staff compliance in maintaining resuscitation equipment.

The major haemorrhage trolley and arterial line trolley were also checked, signed and dated.

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

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Staff completed risk assessments for each patient on admission to the surgical ward and before surgery using a recognised tool and reviewed this regularly. Patient records we looked at included risk assessments for venous thromboembolism (VTE – blood clots), pressure ulcers, nutritional needs, risk of falls and infection control risks. Staff told us they screened patients for suspected sepsis and utilised the sepsis six care bundle if required.

Staff we spoke with knew about and gave examples of risk issues. They used national early warning score systems (NEWS2) and carried out routine monitoring based on patients' individual needs to ensure any changes to their medical condition could be promptly identified. Patients who were considered as high risk were cared for using care pathways and plans were put in place so they received the right level of care. Staff carried out observations at least every four hours so any changes to the patient's medical condition could be promptly identified. We looked at four patient records and these showed that patients were reviewed regularly and escalated appropriately when required.

The hospital had policies in place that were compliant with both national safety standards for invasive procedures (NatSSIPS) and local safety standards for invasive procedures (LocSSIPS).

The deputy ward manager was the falls champion and they checked the falls policy was being adhered to and that staff used the correct pathway. Ward staff used a red, amber, green (RAG) rated system for managing patients identified at risk of falls which was clearly illustrated on a board and updated daily. Patient rooms had signage to indicate the level of falls risk to inform staff of the level of care and support required for that patient, such as enhanced observations and physiotherapist support.

A monthly early warning score audit was completed across the surgical services to assess compliance against the hospital's policies and National Institute for Health and Care Excellence (NICE) standard CG50 (Acutely ill adults in hospital: recognising and responding to deterioration). The audit results for February 2022 to April 2022 showed monthly compliance ranged between 98% and 99%.

The service had an exclusion criteria that identified patients who could not be admitted for treatment. This included those with an American Society of Anaesthesiologists (ASA) classification level three or four (complex health needs). These patients were referred to an NHS acute hospital or another Spire hospital with a critical care unit instead.

We observed a theatre team undertake the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) safer surgery checklist. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures. The final 'sign-out' check was initiated by the relevant staff before the surgeon left the room. However, staff told us that there were occasions when surgeons did not stay for the final sign-out step.

We looked at the records for four patients who had recently undergone surgery and these showed safer surgery checklists were mostly completed correctly. We observed one safer surgery checklist that did not have the sign out stage completed in one patient record.

However, the theatre manager told us that audits were completed monthly to check staff compliance against the safer surgery checklist. This included an observational audit to observe staff practice. Audit results showed staff compliance was 100% between February 2022 to April 2022.

Theatre staff carried out safety huddles prior to commencing surgical procedures and conducted a de-brief at the end of each theatre list. We observed a huddle prior to surgery which involved an introduction of the team and discussion of the patient's pathology tests, VTE risk, patient allergies and their level of health needs based on ASA classification.

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The hospital had a transfer policy and a service level agreement in place to send patients to the closest NHS hospital if their health deteriorated during or after surgery. Where a patient's health deteriorated, staff told us they would always alert the onsite resident medical officer and where appropriate the resuscitation team.

The consultants and anaesthetists were trained in life support training at a level relevant to their role. The RMO was onsite 24 hours per day, seven days a week and led the resuscitation response. They were trained to advanced life support (ALS) and European Paediatric Advanced Life Support (EPLS) level. Consultants with practising privileges completed life support training at their host trust and compliance with mandatory training was a requirement of the approval of their annual appraisal.

Data provided showed that 96% of theatre staff and 90% of ward staff had completed either advanced life support (ALS), immediate life support (ILS) or basic life support (BLS) training. At the time of inspection there were 13 theatre staff and 25 ward staff trained in ILS. Additionally, eight theatre staff and two ward staff were trained in ALS. Senior managers told us that of the twelve staff who had not yet completed their life support training, six of them were new starters.

The hospital had a resuscitation lead who attended the hospital regularly and checked resuscitation trolleys, updated checklists and monitored ILS and BLS training. There was a hospital-wide emergency response team that was made up of alternating multidisciplinary staff with ILS and ALS training. The resuscitation team carried bleeps and responded to emergencies. We observed a daily resus huddle with the staff which tested their bleeps worked correctly and confirmed their roles for the day.

The service did not treat children and young people, but senior managers told us that most clinical staff completed paediatric basic life support (PBLIS) training. This meant staff had been trained to deal with an emergency involving a child visitor.

The hospital had three recovery beds to accommodate patients immediately after surgery. The theatre manager told us that the small recovery space was top on the theatre department risk register. If the three recovery beds were all in use with patients who needed to stay in recovery longer than anticipated, then it could occasionally lead to cancelled surgery appointments. The theatre risk register also had equipment identified since two superficial burn incidents occurred within the last 12 months. Root cause analysis, learning points and on-site training had been completed to mitigate the risk of reoccurrence.

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 in the ward and theatre areas were maintained with bank staff, agency staff or existing staff working additional hours.

Staffing levels were based on the 'safer staffing' acuity tool. This meant staffing levels could be adjusted daily according to the number of patients and their needs. The ward manager told us they had adjusted staffing levels when a patient had to stay longer than expected and they also had a manager on-call system.

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The ward and theatre managers carried out daily staff monitoring and escalated staffing shortfalls as part of the daily hospital-wide and departmental huddles. We observed a daily nursing staff handover and it included discussions about patient needs and any staffing or capacity issues. Staff also used a red flag system to escalate unsafe staffing levels. There had been no red flag staffing incidents reported by the surgical services during the past 12 months.

We observed a daily safety meeting with the hospital director, director of clinical services and department heads. These meetings took place every morning and updates were cascaded to staff across the hospital with a printed bulletin. We saw that managers discussed planned and actual staffing levels, looked at the skill mix of available staff and could decide if they needed to release a staff member from one department to another.

The ward and theatre areas we inspected had sufficient numbers of trained nursing and support staff with an appropriate skill mix. We looked at planned and actual staffing levels for the previous four weeks and found that actual staffing levels were safe and higher than planned every day for this period. For example, throughout April 2022 the average number of ward staff planned for the morning was 3.3 whole time equivalent (WTE) and the actual average number of staff was 5.1 (WTE). Shifts during the day were mainly covered by three registered nurses and three healthcare assistants. Night shifts were mainly covered by two registered nurses and one healthcare assistant.

Contracted ward staff consisted of one ward manager, one team leader, seven senior registered nurses, 3.2 (WTE) registered nurses, four apprentices, 9.1 (WTE) healthcare assistants and a deputy director of clinical services.

Ward bank staff consisted of four registered nurses, nine senior registered nurses and seven healthcare assistants. The ward manager told us that bank staff were used to cover sickness, training and annual leave to keep staffing levels safe. They had completed a full induction, mandatory training and had regular shifts based on their availability.

The theatre teams were suitably staffed in line with national guidelines, such as the association of perioperative practice (AfPP) guidelines for safer staffing. Contracted theatre staff consisted of one theatre manager, 3.7 (WTE) team leaders, 4.7 (WTE) registered nurses, 12.1 (WTE) perioperative practitioners, 5.8 (WTE) healthcare assistants. The sterile services department consisted of 3.2 (WTE) sterile services assistants and one sterile services team leader.

For theatre bank staff there were two perioperative practitioners, three registered nurses, 13 senior perioperative practitioners of various specialities. There was also one sterile services assistant.

The Pre-operative assessment team consisted of one manager, six registered nurses and two healthcare assistants.

The ward and theatre department had vacancies for one full-time operating department practitioner, one full-time scrub practitioner, one part-time perioperative practitioner (orthopaedic), one full-time senior staff nurse (12 months fixed term contract), one part-time registered nurse, and one part-time healthcare assistant.

The service monitored its agency usage across the hospital and all agency staff completed a full induction. Data for the wards from the previous 12 months showed that agency staff had been used from June 2021 to September 2021. The agency staff usage ranged from 0.3% to 5% during that time period which was in line with the hospital's standard of 5%. The ward manager told us that the hospital had used agency staff on four occasions over the last 12 months to cover last minute staff sickness. On these occasions the same agency staff member was used for consistency. Data for the theatre department from the previous 12 months showed that agency staff had been used every month and ranged from 3.6% to 7.9%. However, there was a decline in agency usage over the past six months ranging from 3.9% to 5.3%.

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Medical staffing

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

The service had enough medical staff to keep patients safe. Surgical procedures were carried out by a team of anaesthetists and consultant surgeons covering a broad range of specialties, such as vascular, ophthalmology, orthopaedic, and general surgery.

There were 175 consultants working under practicing privileges across the hospital, including consultant surgeons and consultant anaesthetists. Patients were reviewed by a consultant on a daily basis.

The consultants and anaesthetists were responsible for their individual patients during their hospital stay and were required to provide on-call support during evenings and weekends. All consultants lived within 45 minutes of the hospital and this was confirmed during the practicing privileges application process. The service had on-call rotas in place for managers and clinical staff which included cover for the theatre team.

The hospital had a buddy system in place for all consultants who had been granted practicing privileges. This was written into the privileges when they are granted, and we observed the database that recorded and monitored compliance with consultants having a named buddy. The hospital director told us that a consultant could have multiple buddy's due to the number of sub-specialities and must live within 45 minutes of the hospital.

Medical cover on the wards was provided by two resident medical officers (RMO) who worked alternate shifts for one week. The RMO was on site 24 hours per day, 7 days a week and was senior on-call support for all staff and consultants, both clinical and non-clinical.

During their shift, the RMO was responsible for providing medical cover on the ward which included the monitoring of patients in the ward areas, prescribing medicines and other duties.

We observed a morning resuscitation meeting that took place daily and staff checked that the RMO felt fit to resume duties for the day. The ward manager gave a recent example of when the RMO had been awake through the night dealing with an emergency so the on-call RMO attended the hospital to take over the shift.

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.

Staff kept detailed records of patients' care and treatment. Records were clear, mostly up-to-date, stored securely and easily available to all staff providing care. Patient notes were comprehensive, and all staff could access them easily.

A patient record audit was carried out every three months and compliance was 100% between February 2022 and April 2022. This meant the service had a high level of compliance for accuracy and completeness of patient records.

We reviewed four sets of patient records for patients that had recently been admitted to the hospital for surgery. The hospital used paper records.

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Files for new patients were created by the ward clerks and included any information or referral letters received from patient's GPs or other healthcare provider.

Files for patients that had been discharged were temporarily, but securely, held within the nurses' office until follow-up telephone calls had been made to the patient. Records were then transferred to the hospital's medical records team for storage.

Three of the four records included fully completed and valid consent forms. The remaining record included two consent forms, for the same date; one was signed incorrectly twice by the patient and the other was signed by the patient and their doctor. However, the record included two additional detailed letters of consent, which clearly set out the risks and benefits of the proposed surgery and were signed by the patient.

All the records we looked at clearly recorded the name and grade of the doctor or nurse reviewing the patient on each occasion. Each entry had been dated and timed.

The care needs for all four patients had been identified as part of their admission and management plan. All four patients had been reviewed by a doctor within 12 hours of admission to the hospital, and this included documentation of the patient's presenting condition and their agreed management plan. Similarly, the records showed that all four patients had been reviewed daily by a senior clinician after their surgery.

All four sets of records showed that pre-operative assessments had been carried out. Nursing assessments and relevant risk assessments, such as Malnutrition Universal Screening Tool (MUST) nutritional assessments and Waterlow (pressure care) assessments had been carried out on admission along with a falls risk assessment. Management of VTE risk included consideration of the need to use pressure stockings or, where appropriate, prescription of prophylactic anti-coagulation medicine.

Three of the four records included fully completed a modified World Health Organisation (WHO) five steps to safer surgery checklist. The checklist included sections for 'sign-in' prior to administration of anesthesia, 'time-out' before incision, and 'sign-out' before the patient leaves the theatre. The remaining record showed that the sign-in and time-out sections had been completed, but the sign-out section had not been. This meant that the service could not be assured that all equipment, instrument, needle and swab counts had been completed. However, there was no indication in the remaining record of any harm to the patient.

All four patient records included correctly recorded and calculated vital sign observations, using the national early warning system tool. Evidence of escalation to a doctor was recorded in two of the sets of records where the relevant trigger score had been met.

All four records included copies of fluid balance charts, which demonstrated that staff monitored each patients' fluid intake and outpatient. This is important to ensure that patients remain hydrated.

There was evidence of antibiotic review in one patient record. One record included an alert sticker on the file cover, and an alert form at the start of the file, to show the patient had been diagnosed with MRSA (methicillin-resistant staphylococcus aureus). Antibiotics had not been prescribed for the other patients.

We did not see any indication of discussions with the patients' relatives or carers in any of the records. However, the hospital was still managing the risks of the COVID-19 pandemic and visiting restrictions (although much relaxed) were still in place. This meant that opportunities to discuss patients' care with their loved ones was limited.

Surgery

One of the four patient records demonstrated evidence that psychological assessment had been carried out; there was no indication that psychological assessment was required for the other three patients.

None of the patient records we reviewed included a Do Not Attempt Resuscitation form; however, there was no indication that any of the four patients would require these.

Medicines

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

The hospital had an on-site pharmacy department that consisted of a pharmacy manager, three pharmacy technicians and three pharmacists. The pharmacy team operated from 8am to 5pm on weekdays, 9am to 12pm on Saturday, and provided on-call cover for the ward and theatre staff at weekends and out of hours.

We observed checklists for the medicine cupboards and controlled drugs. The hospital director was the controlled drugs accountable officer for the service. Staff carried out daily checks on controlled drugs and routine medicine stocks to ensure that medicines were reconciled correctly. Staff signatures were checked at the end of each shift for controlled drugs as an extra security measure.

Staff stored and managed all medicines and prescribing documents safely and securely, in line with the provider's medicines management policies.

We observed a checklist for medicines that were due to expire within three months and a reminder log to alert staff to when the drugs were near expiry.

We saw that medicines that required storage at temperatures between 2°C and 8°C were appropriately stored in medicine fridges. The hospital used an alarm system to alert staff if the temperature went out of range. An audible alarm would sound, and staff would be sent an email regarding what fridge had triggered the alarm. This meant that staff could take immediate action to resolve the problem.

The hospital used paper-based prescribing and medicines administration records. The pharmacy department had oversight of what was prescribed for new patients and checked if it was suitable to be taken alongside current medications. Pharmacy staff also attended the safety huddles at the start of each day.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff completed medicines records accurately and kept them up to date.

We observed checklists for medical gas cylinders, and they were appropriately and securely stored in each area we inspected.

The pharmacy team were responsible for maintaining and replenishing controlled drugs, routine medicines and intravenous fluid bags and carried out routine checks for stock levels and expiry dates. All the medicines we saw were kept safely in locked cabinets and were within their expiry dates.

The pharmacy team carried out a range of medicines management audits that were reported on a monthly and three-monthly basis. The audits were reported at hospital-level and some specific to individual theatres and wards. The audits undertaken included storage and security of medicines, drug charts, antimicrobial stewardship in the last 31 days, and overall compliance with medicines audits.

Surgery

Data provided for these audits during the period between January 2022 and March 2022 showed overall compliance ranged between 94% and 100%, indicating a good level of staff compliance with medicines management processes. However, the compliance for antimicrobial stewardship in the last 31 days was 90%. The hospital had an action plan in place to discuss this area at the next IPC and antimicrobial stewardship meeting, for the RMO and wound care nurse to take swabs whenever antibiotics were prescribed and review any improvements in May 2022.

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.

The governance manager and director of clinical services had good oversight of incidents.

The service had policies and guidance in place for staff on how to identify, categorise level of harm and report incidents. Staff reported incidents and near misses in line with provider policy and were logged on an electronic incident reporting system. Incidents were reviewed and investigated by managers and all serious incidents were escalated appropriately.

The surgical services reported fourteen serious incidents requiring investigation during the past 12 months. None of the incidents related to serious patient injuries during a procedure or to serious patient harm. There was one incident related to a fall and one incident was a post-operative wound infection. There were ten incidents related to post-operative recognised complications, five of which required transfer to an NHS acute hospital for a higher level of care.

There were two incidents relating to superficial burns acquired during surgery. Root cause analysis reports were completed, lessons learnt were documented, duty of candour process followed, policies reviewed, and all appropriate actions were taken. At the time of inspection, the hospital had their patient safety specialist on site to deliver training based on the learning from the superficial burn incidents. The training involved re-enacting the scenario to create a deeper level of learning.

New incidents were discussed at daily hospital-wide huddles each morning. We observed theatre huddle minutes from March 2022 which showed the burn incident had been recorded and discussed. Staff told us that incidents were also discussed at surgical safety meetings, health and safety meetings and they received emails with lessons learnt from incidents.

Senior managers reviewed all new incidents daily to identify any serious incidents that required immediate actions, such as escalation to the corporate provider or external reporting to organisations such as the Care Quality Commission or NHS service commissioners.

The service held rapid response meetings weekly to discuss any trends in recent incidents. Staff gave a recent example of a trend involving human error when staff had not put patient labels on the sample pots and not sent the sample off to be processed. The quality co-ordinator added in another step check within the process and this had reduced the number of incidents. The director of clinical services told us staff could be supported and offered additional training through the rapid response meetings.

We looked at five root cause analysis investigation reports and saw these were completed appropriately with remedial actions in place to minimise future risk. The reports included detailed information such as chronology of events, details of treatment undertaken, root cause leading to incident, duty of candour process and action plans. The hospital provided

Surgery

the most recent compliance report (May 2022) for the completion of investigation actions. Examples of actions included staff training and to discuss the incident at the next surgical safety committee and clinical governance meeting. The compliance report data for January 2022 to March 2022 showed that all actions had been completed on or before the due date with 100% compliance for closing incidents within the hospital's 45 day target.

There had been a total of 71 incidents reported by the ward staff and theatre teams between February 2022 and April 2022. The most frequent incidents reported were for cancellations including staff sickness, equipment issues and theatre being overrun. The theatre manager told us that staff received feedback about incidents from senior managers and that this was used to improve practice and the service to patients.

There was also a surgical safety guardian and surgical safety meetings held monthly to discuss incidents. The briefings were displayed on the governance notice board in the staff corridor.

Learning from incidents was shared through daily summaries, hospital-wide flash alerts, posters on notice boards, bulletins and newsletters. Meeting minutes showed that incidents were also discussed during routine senior management team meetings, medical advisory committee, clinical governance and departmental meetings so shared learning could take place. Lessons learnt included learning from incidents that had occurred at the provider's other hospitals.

Staff we spoke with understood the duty of candour process and gave examples of when this had been followed. The duty of candour is a regulatory duty that relates to openness and transparency with patients if their treatment causes or has the potential to cause harm or distress. We looked at five investigations following on from serious incidents and found staff had followed the duty of candour process. Staff had been open, transparent and gave patients and families a full explanation of what had gone wrong.

There had been no patient deaths reported by the hospital during the past 12 months. There was a process in place for patient deaths to be discussed at the hospital's medical advisory committee. The provider also had a central process for an independent review of all patient deaths, including a review by a medical examiner.

There was a system in place to ensure safety alerts relating to patient safety, medicines and medical devices were cascaded to staff and responded to in a timely manner. We observed a theatre huddle that took place every morning with theatre staff, the ward manager and the director of clinical services. The huddle included a '48 hour flash report' which was used to discuss any serious incidents that had occurred both internally or externally to another Spire service within 48 hours. The report included information on contributory factors and preventative measures identified from an initial review of the incident.

Are Surgery effective?

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

Evidence-based care and treatment

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

Surgery

People's needs were holistically assessed, and their care, treatment and support was delivered in line with legislation, standards and evidence-based guidance. This included guidance from the National Institute for Health and Care Excellence (NICE) and other expert professional bodies, to achieve effective outcomes.

Compliance with NEWS2 and the safer surgery checklist was audited as part of the hospital's comprehensive audit programme. Designated members of staff had the responsibility of completing the audits and did so in a timely manner.

Staff followed up-to-date policies based on national guidance, such as NICE and the Royal Colleges' standards. All care pathways had been developed in accordance with NICE guidelines and the Royal College of Surgeons guidelines.

The hospital received regular updates on national guidance, drug alerts and policy changes by the corporate provider and shared these with staff.

The hospital's consent policy followed guidance provided by the Department of Health and the General Medical Council. We looked at a selection of the policies, procedures and care pathways and these were up to date and based on current national guidelines.

The safe anaesthesia liaison group (SALG) recently updated the 'stop before you block' (SBYB) guidance and we observed posters of this on the walls in the theatre areas. The guidance aims to reduce incidences of wrong-sided nerve block during regional anaesthesia. This meant that theatre staff and anaesthetists in particular had a second checker when administering an anaesthetic block.

The service recently had a visit from get it right first time (GIRFT), overseen by Kings College, London. This national programme is designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change. The director of clinical services told us they spoke positively of how managers ran the hospital.

The hospital had its own dementia strategy which was based on NICE guidance and the national dementia strategy.

Nutrition and hydration

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

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We looked at four patient records which showed staff carried out an assessment of patients' nutritional requirements and used the malnutrition universal screening tool (MUST). We saw that patients' fluid and nutrition charts were completed accurately.

Staff carried out an audit every three months to measure whether patients had a MUST assessment completed prior to surgery. Audit results for the period between October 2021 and March 2022 showed 100% compliance demonstrating full staff compliance.

Patients with specific dietary needs (such as nut free or gluten free) were identified in their pre-operative assessment and dietary requirements for patients were discussed in the daily multidisciplinary meeting with catering staff.

Surgery

Patients were admitted to the hospital according to the operating list to ensure they did not have to fast for longer than required. Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Drinks were readily available and were in easy reach of patients.

Patients we spoke with told us they were offered a good choice of food and drink.

The hospital had separate menus for inpatient and day case patients, with options available for patients with specific requirements, such as vegan, vegetarian, halal and kosher meals.

Patients were given information on fasting times for certain procedures as part of their pre-operative assessments. The ward manager told us that staff assessed patients' fluid intake hourly.

The patients we spoke with told us they were given advice on fasting times prior to admission and were offered appropriate food and drink after their procedure was completed. Staff carried out an audit every three months to monitor compliance against pre-operative fluid fasting. The audit results showed a high level of compliance, ranging from 97% and 98% between October 2021 and March 2022.

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 based on the Gloucester comfort scale with zero representing no pain to four indicating severe pain. Staff used the pain assessment tool to monitor pain symptoms at regular intervals and gave pain relief in line with individual needs and best practice.

The ward manager told us that staff assessed patients pain hourly and followed the hospital policy for pain management effectively.

The pharmacy manager was the pain lead and acute pain symptoms were managed by the surgical consultants.

Most patients that we spoke with were positive about the way that their pain had been managed. Patients told us that if they had been in pain, staff had responded quickly and checked that the pain relief was effective. However, one patient said that their pain relief had been managed more effectively and quickly during the night compared to the daytime when staff were busier.

Staff prescribed, administered and recorded pain relief accurately. Patient records showed that patients received the required pain relief and they were treated in a way that met their needs and reduced discomfort.

A monthly 'pain to trigger' audit to monitor the timeliness of pain relief for patients was undertaken every three months. Audit results across the hospital showed 90% compliance during October 2021 and December 2021 and an increased compliance of 96.7% by March 2022. The audit results showed there had been an improvement with compliance and demonstrated high levels of staff compliance.

Patient outcomes

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

Surgery

The service participated in relevant national clinical audits and had assurance that patient outcomes were within the national expected range. Outcomes for patients were positive, consistent and met expectations.

The hospital submitted data to the Private Healthcare Information Network (PHIN). This is an independent, government-mandated source of information about private healthcare which supports patients to make better-informed choices of care provider. PHIN data from October 2020 to September 2021 did not identify any concerns and showed the service performed in line with national averages. There were no mortality or serious injuries reported, two unplanned return to theatre (less than one per 1000 discharges), six unplanned transfers (two per 1000 discharges) and no unplanned readmissions.

Performance reported outcomes measures (PROMs) data for 2020/21 reported to PHIN showed 100% of patients reported they had improved since their hip replacement and knee replacement surgery and the hospital performed better than the England average.

The national joint registry (NJR) data for 2020/21 showed that patient outcomes, revision rates and mortality rates for hips and knees at the hospital were within the national averages. The hospital was better than expected for obtaining patients consent and better than expected for their data linkability.

The hospital director told us that the PHIN and NJR data was compared with the providers other hospitals and head office provided a snapshot of their performance.

Clinical effectiveness was overseen by the clinical audit and effectiveness committee and a corporate software system recorded all audits undertaken. These included but were not limited to audits on IPC, pre-op assessment, medicines management, records, pain, temperature and hand hygiene. The director of clinical services told us that the audit information was entered into the system.

The system initially provided a hospital-wide summary of the audit data and since April 2022 the provider enhanced this process so each department had their own dashboard. Each department dashboard included information such as complaints, incidents, investigations, quality improvement projects and risk register entries.

The governance manager created a quarterly governance report and provided a high level summary of the data for each department. Managers shared and made sure staff understood information from the audits. Audit findings were reviewed as part of routine departmental staff meetings and as part of the clinical governance meeting and medical advisory committee meetings, held every three months.

The electronic system allowed the service to benchmark against 38 other provider hospitals. This was part of the patient safety scorecard that showed every hospital in the group and ranked them according to performance on each metric. For example, with VTE risks they were amongst the highest.

Competent staff

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

Managers gave all new staff a full induction tailored to their role and their competency was assessed before working unsupervised. Bank and agency staff also had inductions before starting work.

Surgery

Managers supported staff to develop through yearly, constructive appraisals of their work. The theatre manager completed the appraisals for team leaders who then completed appraisals for their staff.

Staff we spoke with told us they received an annual appraisal including a mid-year review. The hospital provided data that showed 100% of ward staff and theatre staff had completed their appraisal.

Consultants working under practicing privileges were required to submit evidence of their clinical appraisal annually from their main employer which was usually an NHS trust. This was reviewed as part of the practicing privileges process and during inspection we observed the database that monitored and recorded all appraisal information.

The service monitored the number of procedures that were carried out per year by each consultant and the medical advisory committee (MAC) discussed performance issues and competency regularly.

The regulatory compliance lead supported the learning and development needs of staff. The ward manager, theatre manager and director of clinical services also provided training support for staff. The director of clinical services told us that staff attended training on various topics such as PPE, IPC, oxygen, asthma and dementia during lockdown periods in 2021 due to COVID-19.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Ward and theatre staff received competency-based training and assessments covering a range of topics. During induction staff completed their core competencies under the guidance of the practice educator. Staff then moved into their departments and continued their core clinical competency training which was monitored by the head of department.

The governance manager told us that the hospital had developed 46 local work instructions for staff to follow and had 21 standard operating procedures. The service developed many clinical competencies at a local level which included sepsis, management of indwelling urinary catheters, haemobank, bedside manner, documentation and communication and clean intermittent catheterisation.

The regulatory compliance lead supported the learning and development needs of staff and students. They completed checks on all staff competencies and oversaw staff competency files and the training database. There was a tracker system for competencies, and this was audited and fed into the audit committee. This system assured managers that staff had the right competencies for their role and were all in date.

The hospital director told us that senior management recently received training from a corporate staff member on risk management. Senior managers then trained each head of department who in turn cascaded the learning to their staff within the departments.

Multidisciplinary working

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

There was effective daily communication between multidisciplinary teams within the surgical wards and theatres. Staff handover meetings took place during shift changes and 'safety huddles' were carried out daily in the ward and theatres to ensure all staff had up-to-date information about risks and concerns. The RMO, pharmacist and physiotherapy staff attended daily safety huddle meetings.

The ward staff told us they had a good relationship with consultants and the resident medical officers (RMO's).

Surgery

We saw theatre staff work together to complete the safer surgery checklist and patient preparation prior to surgery. Staff appeared happy, displayed good communication skills and effective teamwork.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. There were routine team meetings that involved staff from the different specialties. The patient records we looked at showed there was routine input from nursing and medical staff and allied health professionals. The ward and theatre staff told us they received good support from pharmacists, dietitians, physiotherapists as well as diagnostic support such as for x-rays and scans.

The ward manager told us that another multidisciplinary meeting took place every morning with catering, physiotherapy, ward staff and housekeeping. They discussed patients being admitted and discharged that day and which patients needed extra support.

Staff worked across health care disciplines and with other agencies when required to care for patients. Ward staff liaised with several different services when co-ordinating a patient's discharge. This included hospitals, GP's, community services, and social services depending on the area the patient was from.

There was a BUPA health centre on site with their own consultants, GP's and health advisors. The BUPA health centre manager told us they worked well together with hospital staff and there was no division. Communication between the hospital and BUPA staff was good and staff said they felt supported and listened to. The BUPA health manager attended the hospital-wide infection prevention and control committee every three months in addition to the daily safety calls.

Seven-day services

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

Routine surgery was performed in the theatres during weekdays (8am-8pm) and on Saturdays (8am-5pm). The theatres did not routinely operate on Sundays.

The inpatient ward area was open and staffed 24 hours a day, seven days a week.

Patients were reviewed by consultants daily depending on the care pathway. The RMO was on site seven days per week and available on-call during out of hours service. The anaesthetist and consultant responsible for delivering treatment were on-call 24 hours a day if further advice was needed. Ward staff told us that they contacted the anaesthetists and consultants without any issues.

The inpatient ward accommodated overnight patients seven days per week and staffing levels were suitably maintained during out-of-hours and weekends. The day case ward was mainly used for day case patients and operated during normal weekday hours and did not routinely open overnight or at weekends.

The service had on-call rotas in place for managers and clinical staff which included cover for the theatre team, senior managers, pharmacy, physiotherapy and imaging. Physiotherapy support was available on site during normal hours on weekdays with on-call cover during out of hours and weekends.

The pharmacy team operated during normal hours on weekdays, from 9am to 12pm on Saturday and provided on-call cover for the ward and theatre staff at weekends and out of hours.

Surgery

Health promotion

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

Staff assessed each patient's health on admission and provided support for any individual needs to live a healthier lifestyle. Patients identified as consuming high levels of alcohol, being overweight or smokers were given advice and support. This included information on how to access local support services.

The service had relevant information promoting healthy lifestyles and support on the surgical wards. The wards had a range of information leaflets to provide support and advice for patients around healthier living.

The onsite BUPA health centre offered private health assessments carried out by trained health advisers and consultants. Service users could have a one-off assessment or sign up to a 12-month health and wellbeing plan. This included personalised coaching, and information tailored to individual lifestyles and goals.

The health centre had a test room for height, weight, blood pressure, blood samples, hearing, electrocardiogram and skeletal testing.

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 gained consent from patients for their care and treatment in line with legislation and guidance. Staff understood how to obtain informed verbal and written consent from patients before providing care or treatment.

Staff made sure patients consented to treatment based on all the information available. The consent forms we looked at showed the risks and benefits of the specified surgical procedure were documented and explained to the patient. There was a cooling off period after the first stage of consent at pre assessment. When a patient returned weeks or months later the patient completed a confirmation of consent with a consultant. They would repeat the consent process, confirm and resign the consent form.

Three of the four patient records we looked at included fully completed and valid consent forms. One record had been signed incorrectly twice by the patient but included two additional detailed letters of consent, which clearly set out the risks and benefits of the proposed surgery and were signed by the patient.

The hospital-wide consent audit was carried out every three months. The most recent audit results up to March 2022 showed compliance was 100%, which demonstrated full staff compliance.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Mental Capacity Act 2005 and DoLS training was incorporated into the adult safeguarding (level 3) training. We observed information for staff on noticeboards that explained the Mental Capacity Act and DoLS.

There was a flow chart for accessing mental health services displayed in the staff office for guidance and support with relevant phone numbers provided.

The hospital reported there had not been any instances in the past 12 months where a DoLS application had been made.

Surgery

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. If a patient lacked the capacity to make their own decisions, staff told us they sought consent from an appropriate person that could legally make decisions on the patient's behalf. The medical staff were trained to carry out mental capacity assessments in order to determine if a patient had the capacity to make their own decisions.

The director of clinical services was the designated Mental Capacity Act and DoLS lead that provided support and guidance for mental capacity assessments, best interest meetings and DoLS applications.

The fees charged for treatments offered to privately funded patients were clearly stated prior to patients undertaking any care and treatment.

Feedback from the patient satisfaction survey between January 2022 and March 2022 showed that 96% of patients felt fully informed.

Are Surgery caring?

Good 

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed kind and caring interactions between patients and staff. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Staff followed policy to keep patient care and treatment confidential. All patients in the ward area were admitted to individual rooms and kept doors closed when necessary so their privacy could be maintained. We also saw nursing and surgical staff spoke with patients in private to maintain confidentiality.

We spoke with six patients during the inspection. They told us staff were friendly, attentive and caring. Patients spoke positively about the admission process and said that staff had been reassuring before and after their operation. Comments included “the staff were excellent and nothing was too much trouble” “the staff were very good and checked I was comfortable and not in pain” “staff have been lovely and friendly” “staff have checked on me and kept me updated on when I can go home”.

Staff we spoke with were proud of the caring culture within the service which was very patient focused. The breast care nurse worked closely with patients diagnosed with cancer and went above and beyond to offer emotional support. Staff gave examples of when patients were treated with dignity, compassion and empathy. A patient had been too weak to attend hospital for pre-assessment tests, so staff went to the patients home instead and the service had funded counselling sessions for another patient suffering from anxiety.

Surgery

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.

We saw a poster on a noticeboard about compassionate care and a reminder of the '6 C's' which included care, courage and commitment.

The friends and family test is a national survey that measures patients' experience of the service they have received. Most patients were positive about their experience and recommending the hospital's surgical services to friends and family. The test data between October 2021 and March 2022 showed the average monthly responses for patients reporting a good or very good experience across the surgical services ranged between 91% and 98%. The average monthly response rate ranged between 65 and 100 patients per month during this period.

Feedback from the patient satisfaction survey between January 2022 and March 2022 showed that 98% of patients felt that staff were attentive.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We observed theatre staff communicating effectively with a patient and providing reassurance prior to surgery.

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

Staff went above and beyond to help patients access counselling when they needed it. The breast care nurse told us that the hospital had funded counselling sessions for a patient who was extremely anxious after their cancer diagnosis.

Staff gave an example of when a patient with dementia had been accompanied by his wife and a healthcare assistant walked with her round the hospital and reassured her throughout the appointment.

There were five mental health first aiders across the hospital, and they acted as a point of contact for issues related to mental health or emotional distress. A poster on a noticeboard informed staff who the first aiders were and how they could 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. We observed staff speaking with patients clearly in a way they could understand.

Patients and their families could give feedback on the service and their treatment. Staff supported them to do this by asking for feedback before discharge and during the follow up phone calls. We saw evidence of patient and family feedback on a noticeboard.

Surgery

Staff supported patients to make informed decisions about their care. Patients told us the nursing and medical staff fully explained the care and treatment options to them and allowed them to make informed decisions.

Visiting hours were not restrictive and family or carers could visit between 9am and 9pm. At the time of inspection, the number of people allowed was set to one visitor. The ward manager told us that during COVID-19 restrictions, healthcare assistants supported patients to see their family members and loved ones via online video meetings instead.

We observed staff providing a patient and their relative with discharge information and how to contact the service if they had any concerns.

Are Surgery responsive?

Good 

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

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population. The hospital stopped operating normally in April 2020 to increase support for NHS waiting list patients and release capacity at the local Trust to take COVID-19 patients. The director of clinical services told us that the hospital converted the old hyperbaric building into a training centre and delivered hundreds of training sessions for clinical and non-clinical staff. They also converted areas downstairs into a pre-assessment testing room and a walk in/drive through COVID-19 testing centre for staff and patients.

The service gained patient feedback to better understand their needs via the patient experience survey and patient forum group. Feedback from the patient experience survey between January 2022 and March 2022 showed that 96% of patients had a positive admission experience and 94% of patients felt that their discharge was organised and efficient.

The patient forum group included six volunteers from the local community who attended quarterly meetings with senior managers. They visited the hospital to make observations and provided important insight from a patient perspective. Improvements that had been made as a result of patient forum feedback included changes to menus, maintenance of the courtyard, updated patient rooms and environment. One volunteer we spoke with told us they felt comfortable challenging leader's decisions and they felt listened to and valued. They said that the group was powerful in bringing about changes to patient care and treatment.

The hospital provided a range of elective inpatient and day case surgical procedures, including orthopaedic surgery, general surgery, ophthalmology, ear, nose and throat (ENT) surgery, vascular and spinal surgery.

Facilities and premises were appropriate for the services being delivered. The hospital had three operating theatres, two that operated six days per week and had laminar flow, three theatre sessions per day and two sessions on Saturdays. There was also a minor operations theatre located in the outpatient's department. The hospital had capacity to accommodate 25 inpatients with ensuite single rooms and 17 day case patients and was open 24 hours per day, seven days a week.

Surgery

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.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed and staff knew how to access them. Staff used an online interpreting service to support patients whose first language wasn't English. They also used picture books as a visual aid for food, drink and other essential needs.

Patients with certain conditions were excluded from undergoing treatment at the hospital. For example, patients with complex pre-existing medical conditions or a body mass index (BMI) of greater than 40 required an additional risk assessment to ensure their surgery was safe to proceed at the hospital without higher level care facilities. This was outlined in the provider's elective admissions policy.

The service had an equality and diversity policy in place that staff could follow to ensure they did not discriminate, including on the grounds of protected characteristics under the Equality Act, when making care and treatment decisions. Staff also received equality and diversity training as part of their mandatory training.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff completed role-specific training in the Mental Capacity Act and completed competencies in caring for patients living with dementia.

The initial consultations and pre-operative assessments identified patients living with dementia or a learning disability and this allowed the staff to decide whether they could meet the needs of these patients and put plans in place to provide safe care and treatment.

The director of clinical services was the dementia lead and spoke very passionately about supporting patients who were living with dementia. They had made dementia activity boxes that included a handknitted cannula sleeve with small items sewn on. They were lined for added comfort and patients were less likely to pull out their cannula needle while twiddling with the items sewn on it.

Other items in the dementia activity box included old newspapers, playing cards, memorabilia packs and games. This meant patients living with dementia had access to items which could help them engage in activities that were therapeutic, mentally stimulating and beneficial for their wellbeing.

Staff told us patients living with dementia or a learning disability could be accompanied overnight by a family member or a carer. The inpatient ward had two dedicated rooms that were larger and had capacity to accommodate the patient's carer or relative. The environment across the surgical wards and theatre areas had visual aids and dementia-friendly signage in place to facilitate patients living with dementia.

We observed posters on noticeboards that signposted patients and families to dementia support services and a monthly calendar outlined various dementia friendly activities and events. The hospital also had a poster in support of John's campaign which focused on the right of people living with dementia to be supported by their family or carers.

There was also a 'hospital passport' that nurses could fill in with patients. This recorded important information about the patient so that staff could support them in the best way possible. It included information such as anxieties, likes and dislikes, interests and preferred ways to communicate.

Surgery

There were disabled access toilets in outpatients and on the inpatient ward. All patient bedrooms and en-suite bathrooms had disabled access. An independent disability assessment in December 2019 rated the service as compliant.

When patients received bad news, staff adjusted the route out of the hospital so they could be more discreet when leaving.

There was a quiet room for patients to use for prayer, quiet reflection or for those that found the larger waiting areas distressing.

The service had numerous boxes for patients and visitors which included religious texts and prayer mats that were adapted for different religions. Dietary requirements for patients were also considered on pre-admission and the kitchen staff catered for cultural needs, for example halal.

Feedback from the patient satisfaction survey between January 2022 and March 2022 showed that 97% of patients felt that staff understood their needs and 98% of patients felt safe.

Access and flow

People could access the service when they needed it and received the right care promptly. Patient length of stay and discharge processes were effectively planned and organised.

Managers monitored waiting times and made sure patients could access services when they were needed and receive treatment within agreed timeframes. Patients undergoing private treatment did not experience significant delays or waiting times for their treatment. The hospital provided elective surgery across several elective surgical specialties for NHS patients on the referral to treatment waiting lists, under commissioning arrangements with local NHS acute trusts.

There was an average of 436 NHS patients across all surgical specialties on the referral to treatment (RTT) pathway between January 2022 and March 2022. The hospital reported that over 93% of admitted NHS patients began treatment within 18 weeks of referral for each month for this period. Between April 2021 and December 2021, the figure ranged from 93% to 98%. Over the previous 12 months there were two months recorded where one patient waited over 52 weeks from referral to treatment.

The service monitored RTT performance for new and existing NHS patients who had been referred to the hospital for surgical treatment. To maintain patient safety, available capacity was allocated based on clinical need and patients were managed in order of clinical priority, in line with the Royal College of Surgeons clinical prioritisation guidance.

Patients had an initial consultation to determine whether they needed surgery, followed by pre-operative assessment. Where a patient was identified as needing surgery, staff planned for the patient in advance. This reduced the experience of delays in their treatment when admitted to the hospital.

The service had an inclusion and exclusion criteria and patients admitted for treatment were generally healthy or suffered from mild systemic disease and were considered to have a low risk of developing complications during treatment.

Patient admissions were staggered throughout the day so that patients did not have to wait for a long period of time once admitted to the ward. The patients we spoke with told us they had not experienced any delays and found the process to be timely. During the inspection, we did not observe any significant concerns relating to patient access and flow.

Surgery

Managers and staff worked to make sure that they started discharge planning as early as possible. Discharge planning was covered during pre-assessment to determine how many days patients would need on the ward and whether additional support was required at home when they were discharged.

Staff liaised with the RMO and pharmacists so that patients were discharged in a prompt and timely manner. All discharged patients received a follow up call within 24 hours of the discharge and post-operative care and treatment was provided through outpatient appointments.

Discharge summaries were completed by nurses and sent electronically to the patient's GP. This was done immediately via an automated system once the nurse had generated and saved the discharge summary. This included details of the surgery, the implants used and serial numbers for implants where applicable.

There had been 12 surgical procedures cancelled on the day of surgery that were avoidable and 28 cancellations that were unavoidable between May 2021 and April 2022. The main reason for cancellations on the day of surgery were patients not being fit to proceed, staff sickness and COVID-19 self-isolation requirements.

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible. Managers told us cancelled appointments were usually rebooked for that same week or two weeks at the latest.

Managers tracked the rate of avoidable cancellations. In 2021, the average rate was 0.3% which was below the provider average. The hospital director told us this reflected the effectiveness of the hospital's pre-assessment and planning processes.

There had been no instances where patients did not attend their appointment in the previous 12 months.

Learning from complaints and concerns

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

The hospital had a complaints policy and displayed information about how to raise a concern in patient areas. Patients were given leaflets on the complaints procedure and knew how to complain or raise concerns. They were also given the opportunity to give feedback by completing a card on discharge and again during their follow up phone call.

The service had a complaints lead who managed patient feedback and the complaints process. The director of clinical services told us that the complaints lead phoned the patient immediately after receiving the complaint and followed this up with a letter including a complaints leaflet. There was a paragraph at the end of the accompanying letter which told complainant's how to escalate their complaint depending on how their treatment was funded.

Where patients were not satisfied with the response to their complaint, they were given information on how to escalate their concerns within the organisation (to the corporate provider) or to external organisations such as the Parliamentary and Health Service Ombudsman (for NHS patients) and the Independent Sector Complaints Adjudication Service (ISCAS) for private funded patients.

Surgery

Patients were offered face to face meetings with managers to discuss their complaint and talk about their experience. Staff told us this had been very popular with lots of learning opportunities. One example was a patient who had been concerned about the security of their possessions on the day case unit when they were undergoing treatment. As a result, the service installed lockers in all day case rooms.

Managers audited the complaints process to ensure that care was being delivered appropriately and properly. They told us that the service had never breached their two-day complaint acknowledgement target. There had only been one complaint in the past 12 months that had been escalated up from the hospital (level 1 stage) to corporate (level 2 stage) and no complaints had been escalated to external complaint handling organisations.

From April 2021 to March 2022 there were a total of 27 complaints across the hospital. The hospital reported 100% of complaints had been responded to and closed within 20 days between April 2021 and September 2021, 86% between October 2021 and December 2021 and 100% between January 2022 and March 2022. Managers told us that two complaints had exceeded the 20-working day response rate whilst consultants awaited outcomes from a second opinion. However, holding letters had been sent to patients as per policy to keep them informed.

Managers shared lessons learnt from complaints with staff. Staff told us that information about complaints was discussed during daily safety huddles and at routine team meetings to aid future learning. We saw a complaint learning report in the staff office that described a recent complaint, the investigation and the outcome/learning from the situation.

Are Surgery well-led?

Good 

Our rating of well-led improved. We rated it as good.

Leadership

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

Leaders at the service had the right skills and abilities to run the service. The overall lead for the hospital was the hospital director, who was supported by the director of clinical services and the governance manager.

The hospital also had an operations director, finance director, clinical services managers for theatre, imaging and physiotherapy, pharmacy manager, outpatient department manager and ward manager. The medical staff were overseen by the chair of the medical advisory committee (MAC).

There was a clear reporting line for both clinical and non-clinical staff

The ward manager and the theatre manager were responsible for the day to day management of the ward and theatre areas. The consultant surgeons and anaesthetists had clinical responsibility for the patients they treated.

The ward and theatre managers had the relevant skills and abilities to manage the surgical services effectively. They understood the risks to the services and had clear oversight on patient safety, governance and performance issues through daily involvement and quality monitoring.

Surgery

All senior leaders had their own job descriptions and were supported by the provider to complete various development courses. The hospital director attended hospital directors' meetings which included a residential training course. This involved weekly one-to-ones and performance reviews.

Head of departments recently completed bespoke management training for two days a month over three months.

A daily safety and business huddle took place at the start of each day. This was led by the hospital director and involved the senior management team and heads of department. There were regular safety huddles and team briefings in the ward and theatre areas so that staff received all relevant information.

The nursing, support and medical staff we spoke with told us they understood the reporting structures clearly and described their line managers as approachable, visible and said they provided good support.

All staff we spoke with told us that senior management were visible and approachable. They said that managers listened to them and they felt appreciated and valued. Senior managers participated in daily walkarounds of the hospital and the director of clinical services attended all morning meetings such as the morning nursing handover, the resuscitation huddle and the theatre huddle.

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. Leaders and staff understood and knew how to apply them and monitor progress.

The hospital's vision was 'to be recognised as a world class healthcare business' with the purpose to 'make a positive difference to patient's lives through outstanding personalised care'. The hospital's mission statement was 'to bring together the best people who are dedicated to developing excellent clinical environments and delivering the highest quality patient care'.

The hospital had a comprehensive clinical strategy for 2021-2023 with six strategic objectives. These included; 'to deliver safe care in a COVID world, to strengthen data driven clinical improvement performance and to achieve a good or better CQC rating'.

The vision, values and strategic objectives were clearly displayed on notice boards across the ward and theatre areas. The vision and values were saved on every desktop computer, covered in the induction programme for new staff and objectives were incorporated into individual staff appraisals. Most staff we spoke with had a good understanding of the vision and values.

The strategic objectives were underpinned by key performance goals and measurable targets, including for clinical quality, patient safety and medical and clinical governance. The service had action plans in place for the strategy to continually monitor progress.

The hospital also had a patient engagement strategy for 2022 which included objectives that focused on patient forums, learning from complaints, response rates, patient satisfaction results and themes from complaints.

The hospital director was focused on clinical quality and being a good quality provider. The hospital values were derived from the clinical and hospital strategies and senior managers used patient forums to understand and localise these. The senior managers also involved staff in the development of the values.

Surgery

Culture

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

Staff we spoke with were positive about the culture and described it as friendly, open, supportive and patient focused. They were highly motivated and told us they enjoyed working at the hospital. Many staff across various roles had worked in the hospital for over 10 years.

Staff said there had been many improvements over the past few years and they felt listened to, valued and supported by senior management. All staff we spoke with described the leaders as being approachable and visible.

Staff felt safe to raise issues with line managers and said managers responded positively when concerns were shared. They were aware of the whistleblowing policy and understood how to contact the freedom to speak up guardian and ambassadors if needed. There were no freedom to speak up incidents reported from January 2022 to March 2022. Additionally, there had not been any whistleblowing concerns raised by the service or received by the Care Quality Commission during the past 12 months.

We saw a poster on noticeboards highlighting who the freedom to speak up guardians and ambassadors were and the number for the 'raising concerns' helpline.

There was also a policy for raising concerns on a noticeboard for staff to access easily.

Staff were encouraged to report excellence and posters around the hospital reminded staff to look for anything they felt might be excellent so it could be recognised. The hospital celebrated a student nurse who had reached the final stage for 'student nurse of the year award' and proudly presented this achievement on the ward.

There was a loyalty stamp scheme for staff where they were rewarded with a free meal after every ten visits to the hospital café. Staff were also given a free private health assessment at any BUPA health centre as part of their private health insurance package.

The hospital had a database to monitor and ensure that all staff birthdays were celebrated. The director of clinical services told us that there were 41 staff birthdays the following month and they would all receive free lunch vouchers.

We observed numerous emails from surgeons praising the staff for their excellent work and staff we spoke with were positive about working in the surgical departments across the hospital.

There was information on noticeboards to support staff wellbeing such as 'top tips for staying well at work', stress awareness month, the benefits of taking a walk, the importance of taking breaks and a wellbeing action plan checklist.

Staff were focused on the needs of patients and were motivated to give them the best care and treatment possible. The engineering administrator told us they felt they had gone above and beyond to purchase a particular surgical instrument which meant a patient had their operation sooner and more patients benefited from the operation.

Surgery

The hospital encouraged opportunities for professional development with their student programme. At the time of inspection there were eight student nurses training, five of them had been healthcare assistants at the service previously. Some students were due to qualify soon, and senior managers told us they were proud to recruit them into registered nursing roles.

There was also a national apprenticeship programme (NAP) with five apprentices at the hospital. They completed a bespoke education and training programme that the service had developed last year, and managers told us this had proved to be very successful. Most of the students on the NAP programme were already healthcare assistants at the hospital.

Other staff gave examples of how they had progressed in their career and some had moved from clinical roles to higher level non-clinical roles.

There were 14 dignity champions across the hospital and certificates of commitment were displayed on noticeboards. The role of the champion involved standing up and challenging disrespectful behaviour, acting as a role model and treating people with respect.

Data from the most recent staff survey showed that the pride index had increased by 9% from the previous year.

Governance

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

There were clear governance structures in place that provided assurance of oversight and performance against safety measures. There were several groups and committees in place that held meetings either monthly or every three months and reported to the senior management team. These included the clinical audit and effectiveness committee, infection prevention and control committee, medical advisory committee and clinical governance committee.

The medical advisory committee (MAC) held meetings every three months led by the MAC chair. The MAC meetings were attended by the senior management team, fifteen surgical specialty lead consultants and the theatre manager. Meeting minutes for March 2022 showed the MAC undertook reviews of new and updated guidance, consultants' performance, practicing privileges reviews as well as a review of governance and key risks. MAC meeting minutes for March 2022 showed that consultants without cross cover or a recent appraisal in place had their practicing privileges withdrawn until this was rectified.

The MAC governance lead was also the MAC freedom to speak up ambassador and had been at the service for five years. In addition to the MAC meetings they also attended the hospital weekly to meet with the hospital director and director of clinical services. This meeting had an agenda and minuted discussion. The MAC chair told us they discussed any new concerns that had arisen, updates, staffing issues, and positive changes. They went through the annual and bi-annual reviews and highlighted any concerns.

The clinical governance meetings were held every three months and were attended by the senior managers and departmental leads. Meeting minutes for April 2022 showed discussions took place around performance and quality, governance, incidents, complaints, risks and audit performance. Action plans were in place and these were followed up at subsequent meetings.

Surgery

The senior management team (SMT) held meetings on a weekly basis. Meeting minutes for April 2022 showed discussions took place around finance, operations, governance, performance, clinical updates and recruitment. The SMT meetings also reviewed minutes and reports from the various committee meetings held across the hospital.

The hospital director and senior managers held daily and weekly informal meetings to discuss day to day issues.

There were daily morning safety calls with senior managers and all heads of departments that discussed staffing, skill mix, admissions, mandatory training compliance figure (focus of the week), key messages, successes, quality and non-clinical updates. A printed-out summary of the call was cascaded across the hospital immediately after every call for staff to read.

There were daily huddles held in the ward and theatre areas and the ward and theatre teams held monthly clinical staff meetings.

There was regular communication and oversight from the corporate provider. The senior management team and departmental leads routinely reported governance, performance and risks to the corporate provider and the senior managers and departmental managers participated in regular peer meetings to share learning and benchmarking with the provider's other hospitals across the region and nationally.

We spoke with the MAC chair, who told us practising privileges were reviewed every two years and authorised by the hospital director, director of clinical services and the MAC chair and were also reviewed at the medical advisory committee. Consultants were required to submit updated appraisals, GMC registration information and indemnity insurance information to the hospital on an annual basis. They received reminders to submit required documentation annually and individuals who did not submit the required information within required timelines would have their practising privileges suspended. Practising privileges were also removed if individuals had not undertaken any clinical activity for over 12 months, unless there was a valid reason why these should be maintained.

We looked at the electronic database that monitored practicing privileges requirements. We saw that one consultant without an up to date appraisal and another consultant without cross cover had their practicing privileges suspended until they were rectified. Two consultants without indemnity certificates were also suspended until these were in place.

All consultants were compliant with General Medical Council (GMC) revalidation, and Disclosure and Barring Service (DBS) checks.

We looked at ten staff recruitment files across the departments in various roles. These showed evidence that appropriate recruitment and pre-employment checks had been carried out. This included identification checks, qualifications, at least two employment references, Disclosure and Barring Service (DBS) checks and Nursing and Midwifery Council registrations and revalidations.

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.

Routine staff meetings took place to discuss day-to-day issues and to share information on complaints, incidents and audit results. We observed a theatre huddle and staff recited the top three theatre risks on the register.

Surgery

The key risks relating to the surgical services were incorporated into the hospital wide risk register. The risk register showed that key risks were identified, and control measures were put in place to mitigate risks. Risks had a review date and an accountable staff member responsible for managing that risk.

Staff had recently received training on how to record and escalate key risks on the risk register and they were supported by the hospital health and safety and risk lead to review open risks and identify mitigations to reduce or eliminate risks. Key risks and risk register entries were reviewed at monthly departmental meetings as well as clinical governance, medical advisory committee and senior management team meetings.

The hospital director told us that staff discussed any risks or concerns with a head of department who then escalated the risks as necessary. They said that senior management listened to and acted on staff concerns via the 'Feedback Friday' bulletin and the weekly rapid response meetings where trends in recent incidents was discussed. Senior managers believed that these meetings encouraged staff to think about risk and be confident to raise their voice when required. We saw that regular audit and monitoring of key processes took place to monitor performance against patient safety standards and organisational objectives. There was a structured programme of audit covering key processes such as pre-op assessment, medicines management, records, pain, temperature and hand hygiene. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through routine team meetings, safety huddles, performance dashboards and newsletters.

The hospital used an electronic audit and quality monitoring system to record most audits undertaken by staff. Audit reports were collated and produced centrally and shared across the hospital. The audit data was reviewed at routine departmental and hospital-wide meetings and monitored centrally by the corporate provider.

We looked at the patient safety audit dashboard from the previous 12 months. There were eleven measures that included cancer standards, pain trigger to action, temperature control, consent, VTE assessment and falls risk assessment. The performance for the hospital was compared against 38 other provider hospitals. The hospital achieved 100% for eight out of the eleven measures. The remaining three measures ranged between 96.7% and 98.8%. This indicated that performance against patient safety standards was good.

Information Management

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

The service had clear and robust performance measures which were reported at both a national and local level. Data was monitored closely, and all staff had sufficient access to information on performance, quality and improvement.

Performance information was collected and analysed by the surgical services and was used to develop and support the delivery of services. The surgical services had performance dashboards in place that were updated monthly and provided a detailed overview of patient safety, performance and staffing indicators. The clinical dashboards included comparative data over time and comparative data from the provider's other hospitals nationally.

The service used performance data to monitor and measure improvements within the hospital. The most recent MAC meeting minutes showed that improvements were discussed in relation to fluid and fasting times. This area had steadily

Surgery

improved and had consistently achieved over 97% compliance and 100% in some quarters. Clinical governance meeting minutes from April 2022 showed that senior managers discussed and monitored clinical audit performance alongside patient safety and quality outcomes. Action plans were in place to drive forward any improvements that had been identified.

The service integrated the views of patients via patient satisfaction surveys and patient forum groups to implement change. The service recently completed a mini satisfaction survey to drive improvements following the monthly patient's satisfaction survey results.

Staff used electronic systems for planning and monitoring patient flow and theatre utilisation and cancellations.

The clinical governance and complaints lead was the General Data Protection Regulation (GDPR) lead for the service. The hospital reported there had been no data breaches that were reportable to the Information Commissioner's Office (ICO) in the past 12 months.

Computers were available across the wards and theatre areas and staff access was password protected. Staff we spoke with did not identify any concerns relating to accessing IT systems or any connectivity issues.

The ward and theatre areas had several notice boards that displayed information such as safety bulletins which were developed centrally and circulated across the provider's hospitals every month including information on policy updates, national safety alerts, updates to national clinical guidelines and shared learning. Other documents displayed included meeting minutes, quality and performance dashboards, patient safety and infection control information, audit and survey results.

Senior managers told us that any out of date policies on the hospital computer drive had been deleted to ensure that staff used the latest version on the intranet.

Engagement

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

The service carried out an annual staff survey to gain feedback from staff about their experiences. The hospital-wide staff survey (2021) had a response rate of 80% and 89% of staff said they were proud to work for the provider. This illustrated that the pride index had increased by 9% from the previous year. The results showed that 87% of staff said that they would be happy with the standard of care if a friend or family member needed treatment. The staff survey showed the lowest score was 'for being given the opportunity to talk about their progress in the past six months' (67%). The hospital had developed an action plan for low scores in response to the staff survey.

The 2021 consultant engagement survey showed that 93% of consultants rated the quality of care provided to patients as either 'excellent or very good'. In addition, the quality of service provided to consultants by the hospital scored 85% which had increased by 30% from the previous survey.

Staff told us they received support and good communication from their line managers. Staff routinely participated in team meetings and took part in daily huddles across the areas we inspected. The service also engaged with staff through newsletters, briefings and through other general information and correspondence that was displayed on notice boards and in staff rooms.

Surgery

The hospital regularly engaged with patients to gain feedback. This was done via the well-established patient forums and from gaining patient feedback before discharge and during follow up phone calls. Patients also participated in the friends and family surveys, which showed on average 96% of patients were positive about the care and treatment they received between October 2021 and March 2022.

A patient satisfaction survey was also carried out in real time to seek feedback from patients in relation to their journey from admission to discharge, the quality of care, facilities and staff. Reports were issued to the hospital from the central team monthly. The most recent report covering the period between January 2022 and March 2022 showed most patients responded positively and the service scored on average 94% for the survey questions.

The hospital used patient feedback to make numerous improvements to the environment and patient experience. For example, there was a newly refurbished reception area, all inpatient bathrooms had been renovated to wet rooms, and lockers and televisions had been installed in all patient rooms.

We observed a calendar style poster on a noticeboard promoting awareness and celebration events for 2022. Staff explained that many events were celebrated in a way that was inclusive and represented various roles. For example, the hospital celebrated administrative professionals' day in April, nurse's day in May and allied health professional's day in October. This was in response to staff suggestions through the staff suggestion box. Another example of staff involvement and engagement was that staff decided what colour the new reception area would be. This was based on a staff vote and the majority vote chose the final colour scheme.

The hospital produced a weekly feedback newsletter, on a Friday. This was in addition to the organisations '48 hour flash alerts'.

Learning, continuous improvement and innovation

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

The culture across the services was based on innovation, continual learning and quality improvement. Senior managers were particularly proud of the analgesia workshop that had been developed by the pharmacy manager and delivered to staff across the hospital.

Another area that managers were proud of was their quality improvement project that was developed to improve compliance with patient reviews following analgesia. Compliance with patient reviews had impacted on the pain trigger audit score (85%) at the start of 2021. Changes were implemented that included all patient observations being assessed following analgesia within one hour. By the end of the year the pain trigger audit score ranged from 90% to 94%. The figure had increased to 96.7% in March 2022.

The service had improved performance with compliance for theatre fluid fasting times. Consultant anaesthetists, consultant surgeons, ward nurses, theatre team and the pre-operative assessment team worked together to achieve this. In 2019, performance with the provider target of 65% for theatre fluid fasting times was poor and compliance ranged from 10% to 80%. The service made numerous changes that included the introduction of fluid champions. In 2020 compliance ranged from 82% to 100% and in 2021 compliance ranged from 98% to 100%.

Staff were encouraged to identify ways in which the services could improve. We saw examples of staff being acknowledged for excellence through staff awards.






Surgery

The hospital had been awarded VTE exemplar status in January 2020 by the national VTE exemplar centre network for existing track record of excellence in thrombosis care and prevention. In the previous 12 months the hospital consistently achieved 100% compliance with VTE audits. The director of clinical services told us the hospital developed many clinical competencies at a local level, with some such as the VTE competencies being adopted nationally. This had supported them achieving the goal of VTE exemplar status which remained valid for three years.

The BUPA health centre was consistently nominated for centre of the month out of 20 other BUPA centres across partnership sites. The previous year the centre won centre of the month six times and most improved centre.

The hospital scored the highest for consultant satisfaction and engagement compared to 39 other provider hospitals and they achieved third place for business capital. We were told this reflected their drive and investment in equipment.

Outpatients

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

Are Outpatients safe?

Good 

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 received and kept up to date with their mandatory training. At the time of our inspection the mandatory training compliance rate for staff in the department was 95% or above for all mandatory courses. Staff and managers explained that some of the mandatory training requirements for staff reset in April each year and that managers encouraged staff to complete the training as soon as possible after this date.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training courses included health and safety, equality and diversity and information governance as well as other key topics. Additional online training courses were available on the online training system and included training about mental health, learning disabilities, autism and dementia. Managers had access to all training records for staff and staff told us that managers regularly reminded them to complete mandatory and additional training. However, some staff told us that they did not feel there was enough protected time allocated to completing training courses.

Safeguarding

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

Staff received training appropriate to their role about how to recognise and report abuse. At the time of our inspection the adult safeguarding training (levels two or three) compliance rate for department staff was 100%. There were five safeguarding leads at the hospital who had completed level four safeguarding adults training.

Staff we spoke with told us that they had not had to make a safeguarding referral whilst working at the hospital however, they were able to verbally describe the steps they would take if they identified a safeguarding concern.

Outpatients

Managers maintained a safeguarding folder they put together to support staff to access safeguarding information easily. The folder contained the hospital's safeguarding policy, further guidance about safeguarding processes and contact details for the nearest local authority safeguarding department. We noted that not all the hospital's patients lived in the nearest local authority and therefore the contact information provided would not be applicable to everyone.

However, after the inspection the hospital director told us that the process was to contact the hospital's local authority safeguarding team who would then redirect the referral based on the patient's address.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. The department manager was one of the hospital's dignity champions and staff told us that they would seek advice from them if they were unsure about safeguarding issues or concerns relating to abuse.

The hospital did not provide any services for children. However, staff completed children's safeguarding training up to at least level 2. At the time of our inspection, we saw that child safeguard training compliance was 98%.

Staff were available for each consultant's clinic to provide help and act as a chaperone for patients where required.

Cleanliness, infection control and hygiene

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

Cleaning records were up-to-date and demonstrated that staff cleaned all areas regularly. We saw that each room within the department had a cleaning schedule fixed to the back of the door. The schedule listed the areas and equipment in rooms and how often staff should clean them in the current month (daily, weekly or monthly). Staff recorded which cleaning tasks they completed each day. Staff did not clean rooms that they had not used that day however they recorded this on the schedule so that there were no gaps in the data.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. We saw that staff labelled equipment to show it had been cleaned daily or after use. We saw evidence that the department was included within the hospital's quarterly cleanliness and hand hygiene audits. We saw the department was 100% compliant during hand hygiene audits between February and April 2022.

The department had processes in place to ensure that staff cleaned specialist equipment in line with guidance such as the Department of Health Technical Memorandum 01-01: management of surgical instruments (medical devices). For example, staff used disinfectant wipes to clean scopes between patients in the ear, nose and throat (ENT) clinic. After the clinic staff took the scopes to the sterile supplies unit for decontamination. We saw evidence that the department had achieved 100% compliance with the most recent decontamination of nasendoscope audit.

The department waiting area was located near to the main hospital entrance. At the entrance, the hospital provided patients with masks and hand sanitiser. The department displayed COVID-19 signage to encourage patients to wear masks and socially distance. Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff disposed of clinical waste safely. Each room contained separate bins for general, clinical and sharps waste and the hospital had a suitable clinical waste contract in place. See the main surgery report for further details.

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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 met the needs of patients. The main waiting area for outpatients was near to the hospital entrance and reception and a short distance from the main corridor where most of the consultant clinics took place. At the end of the main corridor there was a small waiting room near to the orthopaedic treatment rooms. However, staff told us that this waiting room could sometimes be too busy, and some patients had to wait in other areas.

Staff told us that hospital managers moved the breast care clinic from the main corridor into the diagnostic imaging department. This meant that patients did not have to dress and undress multiple times when moving between their consultant appointment and the diagnostic imaging department. The physiotherapy team were based in a separate area of the hospital so that staff and patients had easy access to the hospital's gym and wellbeing service.

There was a dedicated resuscitation trolley for the department. Staff checked the contents of the trolley daily and recorded this. Emergency equipment also included emergency peri-arrest and anaphylactic shock kits for adults and children. The kits were tagged to show that they were complete, and the expiry date was displayed on the front of each kit. We saw the department had scored 100% in the most recent cardiac arrest trolley checking audit.

The service had enough suitable equipment to help them to safely care for patients. We completed a random sample of specialist equipment and found that each machine had a label showing the last and next service due date. The labels showed servicing was in date for all the pieces of equipment we checked.

All rooms in the department required key code or staff swipe card access. The laser treatment room was in an area of the department only accessible using a staff swipe card. Staff kept the keys for the laser room inside a locked cupboard in the adjacent room. There was clear signage which displayed a warning to people not to enter the laser room as well as a traffic light system to indicate when the room was in use. Staff showed us that the laser had a deadlock system which prevented the door from opening whilst the laser was in use.

Assessing and responding to patient risk

Staff identified and quickly acted upon patients at risk of deterioration.

The hospital followed the American Society of Anaesthesiology (ASA) scoring system to determine a patient's state of physical health and risk of complications and mortality. Managers told us the hospital did not accept patients who were at higher risk, usually above ASA level two. This reduced the risk that patients would experience medical emergencies whilst in the hospital. See the main surgery report for details.

Outpatient department staff received patient's records, including risk information, from the medical records team on the day of their appointments. For new patients, they advised that the hospital's booking team recorded any relevant risk information they had identified during the booking process. Consultants then recorded patient risks during their first consultation and made staff in the department aware.

Staff responded promptly to any sudden deterioration in a patient's health. There were emergency call bells throughout the hospital. The hospital operated a resus team system. Each morning, staff from each hospital department attended a resus huddle. At the huddle, staff were allocated roles within the resus team and bleeps so they could be called to any emergency that might happen that day.

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The outpatient department had a dedicated resuscitation trolley, emergency peri-arrest and anaphylactic shock kits for adults and children. Depending on their role, all clinical staff in the department should have completed basic life support or intermediate life support during their induction period. However, at the time of our inspection, some clinical staff had not completed either course. Data we requested showed 85% had completed basic or intermediate life support training.

During clinic times, consultants were in the outpatient department and able to assist with any medical emergencies. The hospital also had a resident medical officer (RMO) present in the hospital 24 hours a day. Staff told us that they would bleep the RMO if they had any concerns about patient deterioration. If needed, staff would call an ambulance to transfer patients to an NHS hospital and staff told us they would handover all relevant patient information to the paramedics.

The department used a World Health Organisation (WHO) safety checklist for minor operations. Staff recorded patients' vital observations before, during and after their procedures to check for signs of deterioration. We saw that the department was 100% compliant for observational surgical safety checklist audits between February and April 2022.

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 department had enough nursing and support staff to keep patients safe. We saw that department leads liaised with consultant services coordinators to plan staffing in line with consultant clinics. They used the outpatient safer staffing tool to determine the number and skill mix of staff required each day depending on the types of clinic and minor operations taking place. Managers advised that this would happen well in advance so that staff would receive at least three weeks' notice of their shifts. We reviewed the department's safer staffing tool for April, this showed that actual staffing levels were often above the level of staff required.

However, managers and staff recognised that sometimes the complexity of clinics and minor operations placed a lot of pressure on the responsibilities of nursing staff. Managers told us that there were plans in place to upskill healthcare assistants in the department to be able to take on some of these responsibilities. They also told us that plans to move minor operations into the surgery department would also reduce the pressure on nursing staff. Staff we spoke with agreed that the department had enough staff to keep people safe.

However, some staff told us they did not have enough time to complete training, take on additional responsibilities or complete essential administrative tasks such as stock checks. This meant that staff sometimes worked late to ensure that they had completed these. Following the inspection, leaders told us that all staff with allocated roles were provided with sufficient time to complete these tasks and attend any relevant meetings. For example, allocated time was given on the rota and additional hours were built into their staffing establishments to accommodate these extra duties.

The department used bank staff to cover periods of leave and sickness. We reviewed the safer staffing tool for April which showed staffing for the month was 62.5% substantive staff and 37.5% bank staff. Managers told us that the department did not rely on bank staff to meet the required staffing levels, that all bank staff were familiar with the department and received the same induction and training as other staff.

Each morning, the heads of each department attended a senior leadership huddle meeting called comms cell. Managers told us that they would use this meeting to escalate any last minute staffing issues.

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Records

Staff kept detailed records of patients' care and treatment and stored them securely. However, staff did not always have all the information they needed.

The hospital's medical records team prepared patient records one to two days in advance of patient's appointments. Outpatient department staff received patient's records from the medical records team on the day of their appointments. For new patients attending their initial consultation in the department, the patient record often only contained registration and referral information at this stage. However, some staff told us that there had been incidents where patient's referral information was missing from the records they received. They also reported delays relating to the processing of discharge letters. Staff believed this was due to administrative errors in the medical records team. They advised that managers were aware of these issues and that an improvement plan was in place.

Throughout the hospital, staff recorded patient information in paper records. However, some patient information was on electronic systems. For example, there were electronic systems for patients' blood tests, scans or x-rays results. Some staff we spoke with were not sure if the medical records team printed and stored this information with the rest of the patient's record. Following the inspection, leaders advised that the results were printed and filed by the medical records team.

There was a secure record storage area in the medical records department. On the days they needed them, staff stored patient records in secure trolleys in the outpatient department. After each patient's consultation, consultants would update the record and staff would return them to the secure trolleys once patients had booked their follow up appointments at reception. At the end of the day, staff took the trolleys back to the medical records team. Although staff advised that they found this system easy to understand, they told us that they felt the management of patient records would work better if the hospital introduced an electronic patient record system.

Medicines

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

The hospital had an on-site pharmacy and pharmacy team. There were no controlled drugs in the outpatient department.

The hospital had an environmental control system in place. Staff explained that the system would detect if the room or fridge temperatures went outside of the recommended ranges for storing medicines. If this happened, managers and the pharmacy team would receive an alert and dispose of the medicines safely. At the time of our inspection, the department's medicines fridge was waiting for repair, staff stored medicine in a separate department's fridge during this time.

In the department, staff stored other medicines in secure cupboards in treatment rooms. The department used an access control system to manage access to medicines. The system allowed remote key management and created an audit trail to identify which staff members accessed the cupboards and when. The system also allowed for rapid cancellation of lost or stolen keys.

Staff explained that the pharmacy team restocked medicines in the department. We saw evidence that the pharmacy team checked the expiry date on medicines stock in the cupboards monthly. Consultants recorded administration of

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medicines in patient records. However, we could not find evidence that staff recorded the removal of medicines from the cupboards anywhere else and therefore that they could be sure that no medicines were missing. Following the inspection, leaders told us that this was in line with their corporate policy, it did not breach regulations and only registered clinicians had access to these medicines.

The department had a system for monitoring prescriptions in the department. Nursing staff had access to a secure cabinet in the department office where they stored the prescription pads. Consultants would request a prescription sheet from the nursing staff who documented the date, time, sheet number, consultant name, patient identifier and their own name each time they gave out a prescription.

The hospital had a medicines policy and medicines audits schedule in place, see the main surgery report for further details.

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 were able to verbally describe how they used the hospital's incident management system to report incidents and how they knew who would investigate different types of incident. Staff told us the department did not have any serious incidents in the year before our inspection. However, they provided examples of less severe incidents that staff reported. We saw evidence that managers added one of these incidents to the department's risk register because it had happened more than once.

The hospital's director of clinical services met with department managers weekly. At the meetings, they discussed both national patient safety alerts, internal safety alerts and learning from incidents across the hospital group. Managers also received this information by email and ensured this was shared at department level. Staff told us they discussed incidents at outpatient department team meetings. We saw that managers included incidents in the meeting agenda.

Staff understood the duty of candour. Duty of candour requires every healthcare professional to be open and honest with patients when something goes wrong with their care or causes, or has the potential to cause, harm or distress. Staff said they were always transparent and gave patients and families a full explanation if things went wrong. Staff gave examples of when this had happened and how they supported patients.

Are Outpatients effective?

Inspected but not rated 

We inspect but do not rate effective for outpatients.

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. However, staff did not always know how to support patients with mental health issues.

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Staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance. We saw evidence that department processes reflected national guidance such as World Health Organisation (WHO) surgical safety procedures in minor operations and Chartered Society of Physiotherapy (CSP) in the physiotherapy team.

The hospital's overarching policies were produced and reviewed centrally by the hospital group. Staff were able to access all policies on the hospital's computer system. Outpatient department leads also displayed or stored some of these in the department office so that staff could access information quickly. These included policies and processes about safeguarding and mental capacity. Staff told us that they received information about policy changes by email and that managers would discuss significant changes with them at team meetings. The hospital leadership team provided staff with an overview of daily senior leadership team meetings which included a key messages section. Managers told us that senior leaders would share urgent changes to practice with them in this meeting so they could let staff know straight away.

Staff did not always know how to support patients with mental health issues. Some staff we spoke to were not sure if the hospital had any information to give patients who might need support with their mental health. We did not see any patient information leaflets or information about mental health services displayed in patient waiting areas. Hospital leaders showed us that contact information for the local mental health crisis team was displayed in the outpatient department office. However, staff we spoke with were not able to direct us to this when we asked about how they would refer patients who needed support with mental health. Staff told us that the hospital had taken part in promoting mental health initiatives on national mental health awareness day. This included displays and activities in the reception and waiting areas.

Pain relief

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

Patients received local anaesthetic during minor operations. Staff explained they would check with patients that the area was numb before the procedure started and regularly ask them about pain whilst the procedure took place.

Staff told us that patients attending dressings or other clinics could access the wound care lead or consultants if they were feeling pain, they could then be prescribed pain relief if it was appropriate and safe to do so. Staff were aware that patients might suffer pain if they had not been taking their medicine as prescribed, they were able to verbally describe how they might identify this and how they would involve the pharmacy team in supporting the patient to take their medicines properly.

Patient outcomes

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

The department participated in hospital wide and department specific audits. Departmental audits included decontamination of nasendoscopes in ears, nose and throat (ENT) and surgical safety checklist for minor operations. Managers shared and made sure staff understood information from audits. We saw that managers included audit results in team meeting agendas.

See the main surgery section of this report for information about hospital wide audits.

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The hospital routinely collected feedback from patients through a patient survey and broke the results down to department or team level. The department also did specific patient surveys to get feedback in certain specialities. We saw results for a survey of patients who had undergone treatment for varicose veins in minor operations. Results showed that all the respondents said they were happy with their consultation and the care they received during the procedure. For physiotherapy, 100% of respondents in March 2022 agreed that they would rate their care good or very good and 90% agreed that the team had considered their personal goals. We reviewed patient testimonies about the care they received under the breast care clinic. Testimonies were consistently positive.

The hospital provider participated in relevant audits and the collection of patients reported outcome measures (PROMs), see the main surgery report for details.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers told us that the skill mix in the department was approximately 30% registered nurses and 70% healthcare assistants, which they felt was above the skill mix required to meet patients' needs. However, they told us that there were plans in place, with practice education leads, to upskill healthcare assistants to reduce the demands on registered nurses in the department.

Managers gave all new staff a full induction tailored to their role. Managers showed us the hospital provider's new starter induction checklist that outlined the areas managers should cover with all new hospital staff. This included the history of the provider, its values, policies, training, health and safety as well as introductions to key members of staff and their team. Staff we spoke to told us that they remembered having an induction when they started working at the hospital.

Managers also expected staff in the department to achieve several role specific competencies. These included safe transfusion of bloods, decontamination of scopes, using specialist equipment and other competencies relating to the specialities in the department. Competent peers signed-off the competencies when staff completed them, and managers kept records of the competencies each staff member had achieved. The department had access to a clinical education facilitator who supported student nurses.

Managers and staff participated in the hospital's enabling excellence appraisals process. Staff and managers set developmental objectives which they reviewed halfway through and at the end of the year. Staff we spoke with said they had completed their appraisals. At the time of our inspection we saw that 100% of staff in the department had an appraisal in place. Staff did not have formal supervision meetings with managers, but they told us they received regular informal support and that managers would provide help if they needed it.

Managers had access to staff training records on the hospital's online training system. We saw that staff were able to complete mandatory and additional training online. However, some staff we spoke with said they often did not have time to complete additional training to develop their skills and knowledge.

The department staff attended outpatient safety huddles each morning. During the huddle, managers told us they would discuss the department's activity, any staffing issues and share key messages. Managers organised regular team meetings and encouraged staff to attend them. However, staff and managers explained that it was difficult to get all staff together at the same time due to varying shift patterns and the extended opening hours for the service. We saw that managers prepared an agenda for team meetings and shared the minutes of meetings with all staff by email.

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Multidisciplinary working

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

Although consultants did not attend team meetings, staff told us that there was a positive working relationship between the consultants, nursing and healthcare assistant teams. Managers assigned nursing or healthcare staff to each consultant clinic to ensure that consultants and patients had support and that the department had oversight of patient's care. We saw consultants and healthcare staff discussing the needs of individual patients and their plan for ongoing care.

Physiotherapy staff described how they would liaise with other outpatient department staff to support patients. For example, they told us about how they would talk to staff in the department about how to support patients who raised concerns about their wound dressings whilst attending physiotherapy appointments. As a result, wherever possible, staff would support patients to access the dressings clinic on the same day instead of having to wait until the next clinic or make new appointments.

Staff explained that consultants would complete clinical history and consultation outcome forms for each patient following their clinic appointments. Department staff would then put all relevant documentation in the patient's record for the team or practitioner who would be seeing the patient next. They would also share relevant information with the patient's GP or NHS acute hospital where necessary.

Seven-day services

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

The department facilitated clinics throughout the day and in the early evenings on Monday to Saturday each week. Managers planned clinics in line with consultant availability and patient demand. Managers told us that the department did not experience long waiting lists. Patients we spoke with said they did not wait long for their consultation. The hospital collected data about referral to treatment waiting times, see the main surgery report for details.

Health promotion

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

Staff explained that consultants would take a patient's clinical history from them during their consultation and give them any relevant advice to improve their general health. Physiotherapy teams also encouraged patients to access clinics such as pilates to improve their health and wellbeing.

We saw that the service had health promotion information available for patients to take home. For example, waiting areas had health awareness boards which contained patient information leaflets about topics such as smoking cessation, dementia, endometriosis and breast care.

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.

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Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff completed safeguarding training that included mental capacity. There was further information for staff on mental capacity and deprivation of liberty safeguards (DoLS) in the department's safeguarding folder. Staff were able to verbally describe how they would check if a patient understood them and where to find the processes to follow if they thought they didn't.

Consent processes began in outpatients for most patient pathways. Patients would opt-in verbally when they attended their consultation. Patients would then give written consent as part of the booking or pre-op assessment process depending on what procedure they were going to have. Staff explained that there were robust consent processes for patients having cosmetic surgery. This was in-line with national guidance to ensure that patients had a 14-day cooling off period after deciding to have cosmetic surgery.

Are Outpatients caring?

Good 

We rated caring as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw that staff took time to introduce themselves to patients and carers and thanked them for waiting. Patients and carers, we spoke to said that staff had been polite and professional towards them. We saw consistently positive patient experience feedback, one patient wrote "I've had nothing but the best care and support throughout my journey".

Staff understood patient confidentiality and had completed training about information governance.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. However, staff we spoke with did not know if the service had any information to give to patients who they thought needed mental health support.

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. They were able to verbally describe how they were empathetic when they had to have difficult conversations with patients. One patient said the breast care clinic staff had were "a great support from my diagnosis right through. I could not have wished for a better team".

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Staff supported patients who became distressed and helped them maintain their privacy and dignity. Managers told us that the hospital had moved the breast care clinic into the diagnostic imaging area of the hospital to protect the privacy and dignity of patients. This meant that patients did not have to dress and undress to move between the clinic and the imaging department.

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.

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. They talked with patients, families and carers in a way they could understand, using communication aids where necessary. Patients we spoke with told us that staff had explained any treatment options to them clearly and they felt that they had been given choices. However, we saw one patient survey where a patient said they felt that staff should give patients more time to think about paying for treatment after they have received scan results.

Patients and their families could give feedback on the service and their treatment. The department scored highly on all the patient surveys we looked at. Patient survey results were displayed throughout the hospital.

Are Outpatients responsive?

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. It also worked with others in the wider system and local organisations to plan care.

The hospital offered services to self-funded or privately insured adults as well as NHS patient referrals on a contractual basis. This meant that patients were not just from the local area as patients from further away could refer themselves if they wanted to.

Managers planned clinics in line with consultant availability and patient demand. Patients we spoke with said they did not wait long for their consultation.

Managers told us that the department did not experience long waiting lists. However, staff told us that demand had increased for almost all clinics.

Facilities and premises were appropriate for the services being delivered. The design of the environment met the needs of patients and was accessible for patients with mobility issues. The main waiting area for outpatients was near to the

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hospital entrance, reception and a short distance from the main corridor where most of the consultant clinics took place. The hospital had a large car park for patients, families and carers however, the hospital was more difficult to access for patients who did not have their own vehicles. For example, the hospital was not within walking distance from main train or bus stops.

There were refreshments available in waiting areas and the hospital had a restaurant on site.

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

Meeting people's individual needs

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

Staff made sure patients living with learning disabilities and dementia received the necessary care to meet all their needs. Staff showed us the provider's hospital passport. If they wanted to, patients and carers recorded information in the passport about how staff could support them best with communication, anxiety and other aspects of their care. However, staff we spoke with did not give us specific examples of using the passport in the department.

The service displayed information about how it met the accessible information standard. The standard sets out a specific approach to identifying, recording, flagging, sharing and meeting the communication and support needs of patients, carers and families with a disability, impairment or sensory loss. The display showed that patients could request information in large text, sign language, easy read text or braille.

Staff had access to communication aids to help patients become partners in their care and treatment and translation services and hearing loops were available.

The department had access to religious and cultural resources that staff, or patients could use. For example, the service had faith boxes that contained different religious materials for people to use.

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.

Privately funded patients were able to refer themselves to the service. We saw outpatient department patient survey results for October 2021 showed that 91% of patients who responded said they had found it easy to book an appointment. Managers told us they were proud the department was able to offer patients at least 30-minute appointments for their initial consultations so that patients did not feel rushed.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Managers planned clinics in line with consultant availability and patient demand. Managers told us that the department did not experience long waiting lists. The hospital collected data about how long patients waited to be seen after they were referred and then how long they waited for treatment after being seen in outpatients, see the main surgery report for details.

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Managers worked to keep the number of cancelled appointments to a minimum. If they cancelled an appointment at the last minute, they rearranged them as soon as possible. Staff gave us an example where the service cancelled one patient's appointment because the consultant was not able to attend the hospital. Staff apologised to the patient and rebooked their appointment straight away.

Managers and staff worked to make sure patients did not stay longer than they needed to. Staff said they did their best to keep clinics running on time and would apologise to patients if they had to wait past the start time of their appointment.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Staff we spoke with understood how to receive and escalate complaints. The department did not receive any complaints in the year before our inspection. This meant that staff were not able to give examples about how they learned from complaints. However, one staff member told us they had received feedback from a patient about a lack of high-back, raised chairs in the waiting area. They told us that the department had ordered more of these chairs as a result.

See the main surgery report for further information on the hospital's complaints policy and process.

Are Outpatients well-led?

Good 

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.

The department manager led the department with support from senior nursing staff. They were responsible for the staffing, scheduling, governance and day to day running of the department. To do this, they engaged effectively with the hospital's wider leadership team including consultant services leads. Staff told us that department leads were proactive, easy to talk to and happy to help staff with issues as they arose. They said that managers would encourage them to take on lead roles or responsibilities but that they did not always have time to do them. One staff member gave an example of managers making positive changes based on feedback they had given about their responsibilities. Managers kept a record of the skills and competencies each staff member had achieved and encouraged them to widen their skill set.

Vision and Strategy

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

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At the time of our inspection, the department's vision mainly focused on the movement of minor operations into the main surgery department. Managers told us that this would support the department to enhance clinics such as cardiology, reduce pressure on nursing staff and allow department leads to concentrate on maintaining and improving the clinics that the department could offer.

Managers recorded and updated an action plan that sat behind the department 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 enjoyed working in the department and they felt motivated to give good quality care to patients. They told us that managers supported them to achieve positive results for patients and they felt appreciated. Staff we spoke with knew how to raise concerns about colleagues or managers through the hospital's freedom to speak up process or by contacting HR. They said they felt comfortable to raise issues with managers in the department and felt they would be listened to. Many of the staff in the department had worked at the hospital for a long time and said they enjoyed the variety of their role in the department and support from colleagues.

Staff and managers told us that the hospital was inclusive and supportive. The hospital had equality and diversity leads and respected the personal, social, cultural and religious needs of staff. We saw that hospital managers identified a quiet room each day which they allocated for staff to take time out or use for prayer.

Staff said they felt supported to develop their career if they wanted to. Managers encouraged healthcare assistant staff to consider the nursing apprentice programme to further their career. Some staff told us they had the opportunity to do the apprentice programme, but they had decided not to do it.

Managers encouraged staff to be open and honest with patients and their carers and they understood duty of candour.

Governance

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

Managers operated effective governance processes in the department which fed into the hospital's wider governance structure. They held regular team meetings and daily huddles in the department and would escalate any issues into hospital management huddles or clinical governance meetings. Managers attended the hospital's clinical governance and clinical effectiveness meetings where they discussed and shared performance, clinical incidents, safety alerts and policy updates and reviews. They would then share relevant learning and updates with staff during department meetings. We saw evidence that managers included learning from incidents at department level meetings. Staff told us that managers were proactive about ensuring that they knew the most up to date policies and processes relevant to their work.

See the main surgery report for further information on the hospital's governance structures.

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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.

Managers recorded and updated a risk register for the department. At the time of our inspection, we saw that the department's top three risks were related to mislabelled blood samples, discharge data input in medical records and staffing for minor operations. Managers had escalated these issues through relevant meetings in the hospital and had an action plan in place to mitigate each risk. For example, the department had plans in place to move to an electronic labelling system for blood samples. Managers escalated any risks to service delivery to senior management in the hospital.

See the main surgery report for more information on the hospital's risk register and business continuity plan.

The hospital had an electronic system for tracking and recording a comprehensive audit schedule. Staff were aware of audits that took place in the department and the wider hospital and understood how they contributed to performance.

Information Management

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

The hospital operated electronic systems for managing risks, audits, managing incidents and other performance indicators, see the main surgery report for further information.

Engagement

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

The hospital actively engaged with staff and patients through surveys. They used 'you said, we did' displays to let patients and staff know about changes managers made based on the results. We saw examples of these displayed in the outpatient department.

The hospital accepted patients from NHS hospitals to help improve the waiting lists for appointments locally.

See the main surgery report for further information on the hospital's wider engagement strategy.

Learning, continuous improvement and innovation

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

The hospital participated in quality improvement programmes such as the Getting It Right First Time (GIRFT) independent health sector pilot. GIRFT is a national NHS programme designed to improve the treatment and care of patients through in-depth reviews of services, benchmarking, and presenting data driven evidence to support change. The hospital participated in an independent sector pilot of the programme which focused on spinal and orthopaedics.

Outpatients

See the main surgery report for further information on the hospital's learning, quality and continuous improvement activities.