Phoenix Hospital Investments Ltd

Phoenix Hospital Chelmsford

Inspection report

Essex Healthcare Park
West Hanningfield Road, Great Baddow
Chelmsford
CM2 8FR
Tel: 01245801234
www.phoenixhospitalgroup.com/our-locations/phoenix-hospital-chelmsford/

Date of inspection visit: 24 May 2022
Date of publication: 15/07/2022

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

Ratings

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

Summary of findings

Overall summary

Phoenix Hospital Chelmsford is a private hospital in Chelmsford, Essex and is a location of Phoenix Hospital Investments Ltd. The location offers a wide range of medical and surgical procedures and aims to meet the needs of patients outside London. Phoenix Hospital Chelmsford is an elective surgery hospital with fully equipped operating theatres, day case rooms and consulting suites, patients can access surgical, diagnostic and outpatient services from this location. Between May 2021 and May 2022, the service carried out 731 procedures.

Patients can access the service by self-funding, from insurance agreements and some limited NHS choices.

This service was registered by the Care Quality Commission (CQC) on 1 November 2019, and this was our first inspection. We inspected the service on 24 May 2022, at its location in Chelmsford and inspected three core services including surgery, outpatients and diagnostic imaging.

At the time of our inspection the hospital director was in the process of registering with the CQC to become the registered manager and take on the day to day oversight and leadership of the service. This role was previously performed by the CEO, but given the different locations owned by the service, the service deemed that a permanent registered manager at this location was appropriate to support ongoing developments and provide consistent leadership locally.

The service is registered to provide the following regulated activities:

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

The main service provided by this hospital was cosmetic 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 rated surgery, outpatients and diagnostic imaging as good, and the service as good overall.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good	This was our first inspection of the service. We rated it as good because: • The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. • 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: • The service did not have a risk register for diagnostic imaging, however due to the nature of the service local risks were being escalated to the registered manager through staff meetings and being mitigated through the governance meetings. Diagnostic imaging is a small proportion of hospital activity. The main service was cosmetic surgery. Where arrangements were the same, we have reported findings in the surgery section.
Surgery	Good	This was our first inspection of the service. We rated it as good because: • The service had enough staff to care for patients and keep them safe. Staff had training in key skills,

Summary of findings

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.
- 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:

- Staff did not consistently record ambient room temperatures where medicines were stored.
- Staff did not always achieve the required compliance for mandatory training specifically in relation to Venous thromboembolism (VTE) and chaperoning.

We rated this service as good because it was safe, effective, caring, responsive, and well-led.

Summary of findings

Outpatients

Good

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

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

- Staff did not consistently record ambient room temperatures where medicines were stored.

Summary of findings

- Managers did not ensure staff completed training in relation to venous thromboembolism (VTE) and chaperone training.
- The service did not retain records of outpatient consultation, unless the patient went on to have a minor or surgical procedure.
- Consultant completion of the VTE risk assessment was inconsistent.

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.
We rated this service as good because it was safe, effective, caring, responsive and well-led.

Summary of findings

Contents

Summary of this inspection

Background to Phoenix Hospital Chelmsford

Phoenix Hospital Chelmsford is a private hospital in Chelmsford, Essex and is a location of Phoenix Hospital Investments Ltd. The location offers a wide range of medical and surgical procedures and aims to meet the needs of patients outside London. Phoenix Hospital Chelmsford is an elective surgery hospital with fully equipped operating theatres, day case rooms and consulting suites, patients can access surgical, diagnostic and outpatient services from this location. Between May 2021 and May 2022, the service carried out 731 procedures.

Patients can access the service by self-funding, from insurance agreements and some limited NHS choices.

This service was registered by the Care Quality Commission (CQC) on 1 November 2019, and this was our first inspection. At the time of our inspection the hospital director was in the process of registering with the CQC to become the registered manager and take on the day to day oversight and leadership of the service. This role was previously performed by the CEO, but given the different locations owned by the service, the service deemed that a permanent registered manager at this location was appropriate to support ongoing developments and provide consistent leadership locally.

The service is registered to provide the following regulated activities:

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

The main service provided by this hospital was cosmetic 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.

How we carried out this inspection

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

Areas for improvement

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

Action the service SHOULD take to improve:

Surgery

- The service should ensure that staff consistently record ambient room temperatures in areas where medicines are stored. Regulation (12).

Summary of this inspection

- The service should ensure it improves its training rates in relation to Venous thromboembolism (VTE) and chaperone training. Regulation (17).

Diagnostic Imaging

- The service should ensure that there is a risk register in place for diagnostic imaging as the service plans to extend diagnostic imaging services. Regulation (17).

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	Insufficient evidence to rate	Insufficient evidence to rate	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Good	Inspected but not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Diagnostic imaging

Safe	Good
Effective	Inspected but not rated
Caring	Insufficient evidence to rate
Responsive	Insufficient evidence to rate
Well-led	Good

Are Diagnostic imaging safe?

Good

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

Mandatory training

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

The service employed two bank radiographers. Staff said they had completed mandatory training and evidence provided from the hospital did not separate radiographers from theatre staff.

Medical staff worked at the service under practising privileges. They completed mandatory training in their primary job and provided evidence of completion at appropriate intervals to evidence compliance. Managers collated evidence within an electronic database which alerted them by email when updates were required.

Please see surgery for more information.

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 had training on how to recognise and report abuse they knew how to apply it. Staff were aware of their responsibilities in relation to safeguarding vulnerable adults and children.

Staff we spoke with said they had received safeguarding training to level two.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.Staff demonstrated a good understanding of safeguarding adults and children, including, how to identify those at risk of, or suffering harm from abuse or neglect. Staff could access an up to date safeguarding policy that outlined procedures for managing and dealing with safeguarding concerns.

Good

Diagnostic imaging

We reviewed the safeguarding policy in place and found it to be detailed. The policy covered topics dealing with adult and children safeguarding, child sexual exploitation, female genital mutilation, modern slavery and human trafficking, patients requiring advocacy services and the rights of people subject to Mental Health Act 1983.

Staff who used the imaging equipment primarily supported the work of theatre staff within surgery. Radiographers primarily supported consultants within surgery.

Please see surgery for more information.

Cleanliness, infection control and hygiene

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

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records demonstrated the areas were clean and compliant for the ultrasound room from March 2022 to May 2022 with no gaps.

Staff followed infection control principles including the use of personal protective equipment (PPE). The ultrasound room had gloves in a range of size along with access to antibacterial hand gel and also handwashing and drying facilities.

The service generally performed well for cleanliness. Staff completed audits which included sharps, PPE, handwashing, clinical environment and uniforms to assess compliance. These l audits demonstrated 100% compliance.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Cleaning schedules for the ultrasound room were available evidencing when staff had cleaned equipment after patient use.

Environment and equipment

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

The design of the environment followed national guidance. Please see surgery report.

Staff carried out daily safety checks of specialist equipment.of the service kept a maintenance log of equipment. Staff completed checks for lead coats and removed any that were not suitable for use.

The service had suitable facilities to meet the needs of patients including areas where they could sit comfortably and wait for their procedure. Lockers were available for patients to place personal items, and these were located within the patient's changing room. The service provided clear signage for fire exits and locations of fire extinguishers.

The service had enough suitable equipment to help them to safely care for patients. The hospital had an ultrasound machine, and two image intensifiers. Radiography staff had access to protective equipment for undertaking scans. There was suitable signage showing the room was a controlled area for radiation and we saw this in use during our inspection.

Staff disposed of clinical waste safely.

Good

Diagnostic imaging

Assessing and responding to patient risk

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

The service's referral form for a scan within theatre included prompts to ensure the referrer had, where appropriate, discussed pregnancy risks with the patient, and identified any additional needs to support such as mobility.

Please see surgery for more information.

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.

There was no full-time radiography lead within the service. The radiation protection supervisor was a bank member of staff who worked one day a week and primarily supported consultant-led pain clinics. The service employed another bank radiographer to cover for any annual leave and to provide cover at short notice. Three consultants within surgery also used the imaging equipment. Following the inspection we saw evidence that the consultants had been trained to use the equipment.

The service had an induction checklist which they used to assure themselves staff had a good knowledge and understanding of the environment and equipment they were expected to operate.

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.

Due to the nature of the service images were not taken for diagnostic purposes. Staff saved a printed image to record needle position during surgery. There was no electronic storage of images so there was a risk that image quality could deteriorate over time.

Please see surgery for more information.

Medicines

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

The radiographers within the service did not prescribe medicine or administer contrast.

Please see surgery for more information.

Incidents

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

Staff knew what incidents to report and how to report them. Staff were able to outline the incident reporting process and how to escalate concerns.

Good

Diagnostic imaging

Staff raised concerns and reported incidents and near misses in line with the service's policy.

The service had no never events relating to radiography in the past 12 months.

Staff received feedback from investigation of incidents from other areas of the service. There had been no incidents within radiography in the past 12 months.

Data supplied form the hospital showed that there had been no incidents between 1 October and 31 December 2021.

Are Diagnostic imaging effective?

Inspected but not rated

We have not previously inspected diagnostic imaging as a single service. We do not currently rate effective for diagnostic imaging.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service had local rules and a radiation safety policy that referenced national guidance.

The service did not provide treatment to persons detained under the Mental Health Act.

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment. There was limited evidence of patient outcomes being used to make improvements and achieve good outcomes.

The service recorded images taken within theatres to evidence needle position within surgery. The service did not audit images taken within theatres. Due to the nature of the service patient outcomes are primarily monitored within surgery.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff files contained recruitment records which showed all staff had relevant qualifications and employment history confirmed prior to starting work.

Managers gave all new staff a full induction tailored to their role before they started work. New employees went through checks as part of their on boarding process. Radiographers had specific competencies signed off by the clinical lead.

Good

Diagnostic imaging

Multidisciplinary working

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

Please see surgery for more information,

Seven-day services

Patients could contact the service seven days a week for advice and support after their surgery.

The service was available Monday to Friday 8am to 7pm and had a dedicated 24 hr helpline for any patients needing additional advice outside of these hours.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff received and kept up to date with training on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We saw evidence of this during our inspection process.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patient's records we examined.

Are Diagnostic imaging caring?

Insufficient evidence to rate

Please see surgery.

Are Diagnostic imaging responsive?

Insufficient evidence to rate

Please see surgery.

Are Diagnostic imaging well-led?

Good

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

Good

Diagnostic imaging

As surgery is the main core service for this provider, some of the evidence will be referred to in Surgery. Please see the Surgery report for information management.

Leadership

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

There was a clear senior management structure within the clinic. Lines of accountability and responsibility at the clinic were clear and staff understood their roles and how to escalate problems.

We found the primary bank radiographer had the skills, knowledge and experience to run the department however they were only one day a week to support a consultant led clinic. Leaders demonstrated an understanding of the challenges to quality and sustainability for the service.

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..

The provider had a vision and strategy for the future to expand the diagnostic and screening services offered by the provider. Staff we spoke with knew about the vision and how their role was important to delivering the provider 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 felt respected, supported and valued and that they could approach any member of staff and challenge practice or behaviour if necessary. Staff were focused on the needs of patients receiving care. The culture encouraged openness, honesty and improvement.

Staff told us they were able to raise issues or concerns they had with their line managers.

Staff we spoke with told us they felt empowered to raise concerns and address any issues the service faced, openly and honestly. Staff told us they had a strong commitment to their jobs and were proud of the team working and the positive impact it had on their patients care and experience.

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 governance process in place to manage the service. The hospital director had catch up meetings with the bank radiographer. We were told that the hospital director fed concerns up through local hospital management meetings and the radiation protection advisory committee. We saw evidence that issues such as equipment and competencies were discussed. The service had processes in place to audit the quality of specialist equipment.

Good

Diagnostic imaging

Management of risk, issues and performance

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

The service did not have a risk register for diagnostic imaging however due to the nature of the service local risks were being escalated to the registered manager through staff meetings and being mitigated through the governance meetings.

Please see surgery for more information.

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.

Staff told us they felt engaged in the day to day operation of the hospital. The bank radiographer said that the hospital director was visible and had a chance to speak with them regularly. They said they felt listened to when they had suggestions related to the service delivery.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Staff told us they were encouraged to learn, develop and improve their skills. The radiation protection supervisor was training hospital staff on a radiation awareness course.

Good

Surgery

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

Are Surgery safe?

Good

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

Mandatory training

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

Staff received and mostly kept up to date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. The service aimed for 80% compliance for mandatory training. Data provided by the service showed staff overall compliance was 85.5% with mandatory training. However, 10 of the 36 mandatory training modules fell below the 80% compliance rate set by the provider, with 12 modules meeting 100%. The hospital director was reviewing all mandatory training to make further improvements in some areas. For example, staff achieved 49.2% compliance with Venous thromboembolism (VTE) and 31.1% with chaperone training which were below the 80% compliance set by the provider, and there was a plan in place to improve compliance.

Managers monitored mandatory training and alerted staff when they needed to update their training. The service had an up to date policy for mandatory training and the manager received weekly updates on staff compliance.

Mandatory training was comprehensive and met the needs of patients and staff. The service offered a wide range of mandatory training that was appropriate to the patient group and included responding to patients with dementia with 97.2% compliance, and disability awareness at 100% compliance.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Staff we spoke with during our inspection told us they received safeguarding training and that managers promoted safeguarding within day to day work activities. For example, mangers held daily safety and risk huddles each day at 10am to highlight any risks, concerns or achievements within the service. Staff told us that safeguarding was promoted at these meetings and managers provided feedback from any concerns with the wider staff team where appropriate.

Good

Surgery

Mangers were trained to level 3 safeguarding adults and children and the services safeguarding lead was trained to level 4, with good links to the local authority safeguarding team should they need additional support. Staff achieved 95.8% compliance with safeguarding adults' level 2 and 90% compliance with safeguarding children level 2, both exceeded the service compliance target of 80%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff told us that managers actively promoted equality and diversity and staff were able to describe the types of protected characteristics under the equality act. Staff achieved 97.9% compliance with equality and diversity training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff gave clear examples of the types of abuse they may see within the service. Staff gave an example of a recent safeguarding referral made in relation to a patient who attended a clinic. Staff explained how they had followed the process and escalated the concern to external agencies for further investigation. Staff we spoke with gave a wide range of examples that may be disclosed or identified in the service for example to coercion and control, Female Genital Mutilation (FGM), modern slavery, emotional abuse, sexual abuse and neglect.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff clearly understood the escalation process for safeguarding, who the main contacts were and how to recognise the different types of abuse. The service had a dedicated chaperone policy and guidance on the chaperone policy was displayed in key patient areas. Compliance with chaperone training was low, at 31.1% but the hospital director was aware of this and plans were in place to increase compliance. The hospital director explained that some areas of the training had fallen below compliance as they had focused on ensuring key areas of clinical training has been completed during the COVID-19 pandemic, for example advanced life support.

The service did not provide any services for children and patients were encouraged not to bring children to appointments with them.

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.

Ward areas were visibly clean and had suitable furnishings, which were clean and well-maintained. The service had identified that its consultation rooms contained carpeted areas, this was on the services capital renewal plan to replace with hard flooring in June 2022.

Equipment was cleaned after each patient contact and equipment that had recently been cleaned was identified with an "I am clean label" so staff knew equipment was clean and ready for use. Daily cleaning records we reviewed from March 2022 to May 2022, in relation to theatres, anaesthetics and equipment showed 100% compliance. Hand hygiene audit data from the ward area showed staff achieved 87% compliance, which also included elements such as access to hand sanitizer, if staff were bare below the elbow, nails cut, and other key areas. Theatre staff achieved 100% compliance for the same audit in May 2022.

Good

Surgery

Staff followed infection control principles including the use of personal protection equipment (PPE). We observed staff wearing PPE to safeguard patients and themselves from possible cross infection. Guidance on the use of PPE, hand washing and hand sanitiser was posted throughout the hospital to remind staff and patients to follow infection prevention and control, (IPC) guidance. Data supplied by the service showed that staff achieved 97.5% compliance with infection control training.

The service had an abundance of PPE including aprons, face masks, and gloves of various sizes. Hand washing guidance was available at each hand washing station and staff decontaminated their hands in line with the World Health Organizations five moments for hand hygiene and *NICE guidance (QS 61 statement three).* This standard states that people should *"Receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care".*

We reviewed IPC processes and practice in theatres during the pre-operative, peri-operative and post-operative phases of surgery, and found these were in line with *NICE guidance (CG 74)* and the prevention of surgical site infections.

In the 12 months before our inspection the surgical site infection rate at the service was is 0.05%, the service saw 1,988 patients during this time. The service has never had a Clostridioides difficile *(C.difficile)* infection outbreak. *Cdif* is a type of bacteria that can cause diarrhoea. It often affects people who have been taking antibiotics. It can usually be treated with a different type of antibiotic.

Staff completed IPC risk assessments as part of the patient pre-admission process and before to any appointments at the service. These included identifying any COVID-19 concerns, *MRSA* risks and any concerns were reviewed by clinical staff prior to any attendance at clinic. Staff used audit to identify how well the service prevented infections. Staff worked effectively to prevent, identify and treat surgical site infections. The service had a registered nurse who was the IPC lead, they demonstrated to us how they carried out IPC audits and published results to show performance and identify any areas that required additional support to achieve the required standard.

Environment and equipment

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

The design of the environment followed national guidance. The service operated from a single-story facility inside a private industrial estate, with free parking and easy accessibility including a drop off and collection point. The main reception was bright and welcoming, and patients had dedicated seating with clear social distancing, access to toilets, fresh water and drinks making facilities and were greeted on arrival by dedicated reception staff. Key areas of the service were restricted and only accessible to authorised staff. The service's patient survey from April 2022, showed that 87.5% of patient felt their overall opinion of their accommodation was 'Good' or better.

The service had suitable facilities to meet the needs of patients. The service had five private consultation rooms, two theatres, eight pods used for day cases, and one minor operations suite. The service also had two rooms dedicated for any patients who required additional overnight stays following treatment.

Patients could access lockable cabinets to store their belongings if they were attending for day cases, there were dedicated gender neutral toilet areas, and patients could access free Wi-Fi and televisions in their respective room or pod.

Patients could reach call bells and staff responded quickly when called. The eight pods used for day cases were in view from the nurse's station.

Staff carried out daily safety checks of specialist equipment and there was a reporting process to ensure that any faults or concerns with equipment could be escalated and dealt with efficiently. We reviewed emergency equipment and found that staff had checked these daily in line with the services procedures for ensuring equipment was safe to use.

The service had a dedicated uninterrupted power supply (UPS) system and secondary generator systems to provide additional electricity for up to two hours to ensure utilities could continue if there were issues with the power supply to the location.

The service had enough suitable equipment to help them to safely care for patients and a wide range of equipment to meet the needs of patients. The onsite facilities manager had oversight of maintenance across the service and we noted service and renewal dates were in place for all equipment. In June 2021, a National Patient Safety Alert (NPSA) was published regarding the 'elimination of risk of inadvertent connection to medical air via a flowmeter' which all providers were required to be compliant with by 16 November 2021. We noted during inspection that the service had capped off the air flow outlets. We spoke with the facilities manager who told us the service had capped these off based on the safety alert guidance.

The service clinical governance and risk lead had access to updates from the Medicines and Healthcare products Regulatory Agency (MHRA) regarding any equipment safety concerns, for example recalls on devices and syringes.

Staff disposed of clinical waste safely. Sharps bins were visibly clean, dated and signed and the service had a service level agreement with an external company for the removal and disposal of clinical and confidential waste.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. The service made sure patients knew who to contact to discuss complications or concerns.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them as necessary. The service had clear systems and processes in place to assess and respond to patient risk. Staff used the national early warning scoring system (NEWS2). This tool enables clinicians to use patients' vital signs such as heart rate and blood pressure to identify and escalate concerns relating to a patient's condition. We checked 11 patient records and found all were fully completed and accurately scored. Staff knew how to escalate deteriorating patients and the service had a dedicated "transfer out" process to a local NHS trust should a patient need to be escalated for urgent emergency treatment. In the 12 months before our inspection the service had transferred two patients in line with its transfer out policy. The service was in the process of establishing a service level agreement with a local NHS trust to provide a dedicated transfer out service.

All patients went through a dedicated pre-assessment process to establish levels of risk prior to surgery. Identified risks were assessed and discussed with the consultant and nurse responsible for the patient's care.

At the daily huddle, staff discussed patients NEWS2 scores, patients at risk of falls, patient allergies, or with any specific needs such as those with anxiety or who were needle phobic. Managers shared feedback at the meetings regarding any recent incidents, infection control issues, staffing issues or general safety concerns as well as patient flow. Staff were also given the opportunities to raise any issues they wanted to discuss which could be escalated through the services risk and govrnance processes.

Good

Surgery

The service maintained a clinical governance dashboard which enabled managers and the clinical governance team to have oversight and review clinical indicators and risks within the service. For example, the number of patient falls, sharps injuries, the number of transfers out of service, safeguarding referrals and other key risks within the service.

Staff knew about and managed specific risk issues, such as sepsis, venous thromboembolism (VTE), falls and pressure ulcers. Data supplied by the service showed staff achieved 97.2% compliance with training in sepsis awareness, early detection and care. Staff also achieved 100% compliance with training in relation to care of the deteriorating patient. Managers told us the service very rarely encountered septic patients given the types of procedures being undertaken. The service did not have a sepsis lead at the time of our inspection, but they advised us this was something they were considering in the future, to match up with their other leads, for example the IPC lead.

Compliance with Venous thromboembolism (VTE) training was 49.2% which was below the services 80% compliance level, but plans were in place to increase training compliance in this area. Staff achieved 100% compliance with adult immediate life support training, 75% compliance with basic life support and 62.5% compliance with the basic life support level one workshop.

We observed cases in theatres and witnessed the full completion of the WHO surgical safety checklist. The WHO checklist was audited for observation compliance and audited for compliance and reporting through the services governance processes. We checked the Who checklist audit data for May 2022 and found the surgical safety checklist had been completed before every theatre list.

The service did not store emergency blood on site as they had no service level agreement in place with any blood providers. This was on the service's risk register. The service did not undertake procedures that may involve major blood loss. If there was an emergency during a procedure, staff would follow the service's transfer out policy and call 999 for an emergency response whilst providing immediate life support.

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 staff a full induction.

The number of nurses, medical staff and healthcare assistants matched the planned numbers, and the service had enough staff to keep patients safe. Managers reviewed staffing levels for up to 10 days in advance to ensure they had the right numbers of staff with the right qualifications and experience to keep patients safe.

The service did not directly employ any medical staff, however medical staff worked at the service under practising privileges. The hospital director managed the recruitment and ongoing compliance of consultants who worked at the service under practising privileges. Consultants completed a detailed application and provided evidence of medical indemnity, clinical scope of practice, General Medical Council (GMC) registration, Information Commissioners Office (ICO) registration, enhanced Disclosure and Baring Service (DBS), references, NHS appraisal and immunisation status. Appointments were approved by the services Medical Advisory Committee (MAC). Managers monitored ongoing compliance, including biennial reviews, training and revalidation using an electronic database. The service had a qualified consultant surgeon as its responsible officer (RO). The RO is a senior clinician who ensures that the doctors for whom they act in this nominated capacity, continue to practice safely and are properly supported and managed in maintaining their professional standards.

Good

Surgery

If a patient was required to stay overnight post procedure, in any of the two overnight rooms, the service always had a resident medical officer on site, two qualified registered nurses who were immediate life support trained and access to a consultant on call for additional advice.

Staffing levels could be adjusted daily according to the needs of patients. Staff also had access to a social media app there they could share details regarding shift coverage and requesting additional staff.

The service had increased vacancy rates for nursing staff, which had increased from 14.29% in November 2021 to 42.86% in April 2022. We discussed the vacancy rate and recruitment processes with the management team who explained that a number of staff had taken the decision to retire or leave the service following the COVID-19 pandemic and they were in the process of recruiting new staff or converting bank staff to permanent roles within the service. Due to the nature of patient flow, the managers could use a balance of substantive, bank and agency staff to cover the service without any shortfalls. The service had no vacancies for health care assistants, low nursing staff sickness rates, with a yearly average of 0.04% and a turnover rate of 2.80%.

The service had four regular bank members of staff who were familiar with the service who had regular hours each week depending on the service's requirements to ensure safe staffing levels. Managers made sure all bank and agency staff had a full induction and understood the service prior to them being allowed to work unsupervised.

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 recorded all cosmetic implants on the Breast and Cosmetic Implant Registry (BCIR).

Records were stored securely, patient notes were comprehensive, and all staff could access them easily. The service used paper-based records and patients completed an online preassessment prior to entering the service with key details in relation to their current and past medical history. We reviewed 12 patient records which were detailed and contained information relevant to their care as well as identifying any additional risks within the service, for example any health-related risks, body mass index, or mental health concerns.

When patients transferred to a new team, there were no delays in staff accessing their records. Patients discharged from the service had a summary provided to them, which was shared with their general practitioner or other health care professionals if the patient gave consent.

The service had appropriate processes in place to ensure staff recorded all cosmetic implants on the Breast and Cosmetic Implant Registry (BCIR).

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff were aware of how to access medicines advice and supplies. Pharmacy support was available through the locations head office and there were arrangements for out of hours support. The service also employed nurse prescribers who could also provide staff support.

Staff reviewed each patient's medicines regularly and provided advice to patients. The services patient satisfaction survey from April 2022 showed that 100% of patients said they were given advice on medication side effects.

Staff completed medicines records accurately and kept them up to date. We reviewed 11 medication administration records, which were completed in full and all doses of medication administered were signed for. Allergies were also documented.

Staff stored and managed all medicines and prescribing documents safely. Patients were assessed and could choose to store and administer their own medications. Staff confirmed that post-surgery they would ensure patients took their medicines on time.

Medication was stored in appropriate locked areas, and only authorised staff could access medicines stored in these areas. We found that staff had not consistently carried out daily room temperature checks in the medication storeroom. We escalated this to the manager, and they advised us they would take immediate action to raise this with staff and appropriate checks would be completed. Medication that required refrigeration was stored appropriately and we found staff had consistently recorded refrigeration temperatures and knew how to escalate any concerns regarding any temperature changes.

The ordering, storage and administration of controlled drugs was in accordance with the Misuse of Drugs Act 1971 and the associated regulations. Controlled drugs are drugs that are subject to high levels of regulation as a result of government decisions about those drugs that are especially addictive and harmful. Areas we visited had suitable cupboards to store controlled drugs. Data supplied by the service showed that staff achieved 97.2% compliance with medication awareness training, which was above the 80% compliance target set by the service.

Staff learned from safety alerts and incidents to improve practice. The services pharmacy team audited controlled drug processes and we noted at the daily huddle that any action from audits or incidents was shared with the wider staff team which helped to keep processes safe.

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.

Staff knew what incidents to report and how to report them. The service used an online incident reporting tool, which staff could access from any computer terminal. All staff we spoke with understood the services incident reporting policy and process, and training on how to use the system was given to all staff during their induction to the service.

Records we reviewed during our inspection showed that staff had raised concerns and reported incidents and near misses in line with the service's policy. Between May 2021 and May 2022, the service reported 45 clinical and 13 non-clinical incidents. Incident themes were reviewed by the services management team and scrutinised by the governance team, action plans were implemented to respond to any learning and address any shortfalls in the service.

The service had no never events on any wards. Managers shared learning with staff about never events that happened elsewhere. Mangers we spoke with demonstrated how the governance and risk processes enabled them to review incidents and provide feedback from across its wider service and other locations. Mangers told us this was important as incidents may not happen in isolation and could be repeated in other services if the details and risks were not shared.

Staff reported serious incidents clearly and in line with the service's policy. We reviewed serious incidents and noted staff had reported these timely. Staff we spoke with told us there was a safety culture in the service and that learning from incidents was shared with them including any actions necessary to stop any further incidents.

Good

Surgery

All staff we spoke with understood and were able to explain the duty of candour. The service provided duty of candour training to its staff team and at the time of our inspection staff were 100% compliant. We reviewed a serious incident where the manager had followed duty of candour, staff were open and transparent and gave patients and families a full explanation when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us they received feedback at the safety huddles, they also received feedback on a one to one basis or through emails. Staff had the opportunity to discuss feedback from incidents and there was evidence that changes had been made as a result of feedback. For example, changes to the way needle stick injuries were reported and manged as a result of an incident.

Staff who carried out incident investigations were appropriately qualified to carry out the investigations and had external accreditation as well as significant experience of incident management. The freedom to speak up guardian (FTSUG) met regularly with the hospital director to discuss feedback from staff and the electronic incident reporting system enabled staff to anonymously raise concerns and staff were encouraged to do this if they don't feel that they needed to report any concerns anonymously.

Are Surgery effective?

Good

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. The service met cosmetic surgery standards published by the Royal College of Surgeons.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. All policies were reviewed as part of the service's governance processes and the clinical governance lead had oversight of this process. We reviewed key policies, including but not limited to consent, mental capacity, safeguarding, mandatory training and recruitment and found these up to date and containing relevant links to national and local guidance.

The service met cosmetic surgery standards published by the Royal College of Surgeons (RCOS). For example, details in relation to a 14-day cooling off period was clearly referenced to RCOS in the service's consent policy.

When policies were updated staff were notified by email and during the daily huddles.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We noted staff shared key details in relation to patient needs, patient flow, safety and risk during handover meetings.

Nutrition and hydration

Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

Good

Surgery

The service had a dedicated policy regarding fluid and hydration amongst patients. Patients were advised as part of their pre-admission regarding any need to fast before a procedure. Fasting guidance was in line with *NICE guidance NG180, preoperative care in adults*. Staff informed patients to fast for six hours unless advised differently by their consultant and patients could drink water up to two hours before any procedure.

The services patient satisfaction survey from April 2022 showed that 87.5% of patients were offered enough refreshments after surgery.

Staff did not use a malnutrition universal screening tool (MUST) as patients underwent a thorough pre-assessment and only attended for short periods for any procedures. If staff had any concerns about malnutrition staff would optimise the patient pre-operatively before their surgery, to enhance surgical and recovery outcomes. Patient's nutritional needs were assessed by nurses, in conjunction with the consultant anaesthetist and consultant surgeons' instructions and documented in the nursing notes. All patients were elective surgical patients and received a menu for their inpatient stay when they attended for their pre-assessment. This ensured that patients' nutritional needs, and preferences were met. Additionally, the patient's body mass index (BMI) was calculated at pre-assessment and height and weight re-confirmed on admission.

The ward area had a dedicated kitchen where staff could make drinks and snacks for patients where appropriate. All main meals were brought into the service by an external contractor.

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 within the patients National Early Warning Record (NEWS) and gave pain relief in line with individual needs and best practice. We reviewed 11 sets of patient records, all the records demonstrated that staff had reviewed each patients' pain and recorded this appropriately and that patients received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately.

We spoke with a patient who told us they had received pain relief in a timely way and that staff were response to their needs.

Competent staff

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

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. Staff were given an employee guide, providing useful information to supplement their induction.

Managers supported substantive staff to develop through yearly, constructive appraisals of their work. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge at their appraisals. Mangers maintained records of all appraisal dates and when they were due for renewal. At the time of our inspection 86% of staff had received an appraisal, with one appraisal due in June 2022 to achieve 100% compliance.

Good

Surgery

The service did not offer staff clinical supervision, but they did provide staff with continual professional development opportunities and had a learning and development committee where staff requests for additional training and education could be discussed.

Staff who worked on the bank or agency did not require an appraisal, as this was completed by their substantive employer. However, there were opportunities and systems in place to feed back to the staff member's substantive employers on any concerns or questions regarding staff competencies or training levels within the service.

Nursing staff told us that mangers provided additional support 'on the job' and were available and approachable to ask questions at any time. The managers had an open-door policy and throughout our inspection, we noted staff regularly approaching them for advice and support.

During our inspection we reviewed the providers recruitment policy that covered key areas of employment and preemployment checks carried out by the service. Appropriate processes were in place to ensure all staff had two references, interview notes, Disclosure and Barring Service (DBS) check and occupational health checks. The service had a policy for practising privileges and a dedicated member of staff had oversight of key information including details of references, evidence of professional registration, DBS check, qualifications relevant to the duties and scope of practice for when practising privileges were issued. All staff applying for practising privileges were assessed fully by the services medical advisory committee (MAC), who scrutinised all applications prior to them being accepted and the services responsible officer (RO). The RO is a senior clinician in a designated body who ensures that the doctors for whom they act in this nominated capacity, continue to practice safely and are properly supported and managed in maintaining their professional standards.

Managers made sure staff received any specialist training for their role. The service maintained a suspended list where any staff that had not updated their training, competencies or had any issue with DBS, or reference checks were placed until the MAC were fully satisfied that all necessary checks and evidence of competencies, skills and training were in place.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff we spoke with who had worked in the service for over 12 months told us they had received an appraisal, and this was an opportunity to talk about their development and request additional training or support to carry out their role.

Managers identified poor staff performance promptly and supported staff to improve. The service had up to date processes for managing allegations against staff and practising privileges.

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 multidisciplinary team (MDT) working between all staff groups. Staff and teams worked together in a coordinated way to provide care to patients.

Staff we spoke with reported they had a good working relationship with each other and there were frequent opportunities throughout the day to approach other professionals to help when advice was required.

Good

Surgery

We witnessed effective MDT working during the daily huddles. The huddle had representatives from different departments and gave the opportunity for them to discuss any issues or risks identified at the patient pre-assessment and to allocate the appropriate resources across the service.

Seven-day services

Patients could contact the service seven days a week for advice and support after their surgery.

The service was available Monday to Friday 8am to 7pm and had a dedicated 24 hr helpline for any patients needing additional advice outside of these hours.

Patient outcomes

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

The service participated in relevant audits and outcomes for patients were positive. The service promoted and worked within Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines in order to inform best practice and optimise patient safety. The head of clinical governance worked with the services Medical Advisory Committee (MAC) anaesthetic lead to ensure guidelines were being implemented effectively.

Examples of improvements due to AAGBI actions included that all masks now contained Co2 monitoring in line with recent guidance changes, equipment and anaesthetic machines were routinely checked at least on a daily basis as per the services policy. The service had a system where anaesthetists discharged patients from recovery ensuring and underlining the importance of them remaining within the suite or its environment until the patient had met the AAGBI discharge criteria.

During the 12 months before our inspection, the service introduced recommendations based on *"The measurement of adult blood pressure and management of hypertension before elective surgery, Joint Guidelines from the Association of Anaesthetists of Great Britain and Ireland and the British Hypertension Society, 2016"*. The changes avoided unnecessarily cancelling patients whose blood pressure immediately pre-operatively was elevated purely due to anxiety. The services operating department practitioners (ODPs) knew to discourage pre-induction blood pressure monitoring by anaesthetists who may not have revised their practise in the NHS, and this had significantly reduced cancellation post patient admission.

Managers and staff used the results to improve patients' outcomes. *The Academy of Medical Royal Colleges, Guideline Care for People with Diabetes Mellitus Undergoing Elective and Emergency Surgery 2021*, highlights the importance of separating maintenance insulin and continuing this throughout a surgical procedure and introduces the concept of automated blood sugar monitors. The service had worked with the manufacturers of automated blood sugar monitors who provided generic monitors which allowed staff to offer this system to all insulin dependent diabetic patients who attended for procedures. Staff could also monitor patients who had already enrolled using the services devices with their own sensors. The system also enabled ward staff to continuously monitor blood sugar readings post operatively.

At the time of our inspection the service told us that a Venous thromboembolism (VTE) audit had been developed and was in the process of being rolled out across all the providers locations, so no data for VTE compliance was available. However, staff completed a VTE risk assessment on all surgical patients and this was signed off by either the consultant surgeon or the anaesthetist.

Good

Surgery

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service carried out a range of local audits to drive improvements and maintain standards, for example infection prevention and control (IPC), environmental standards and hygiene, consent, medicines, the World Health organisation (WHO) surgical checklists and pain relief amongst others.

Health promotion

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

Staff assessed each patient's health both prior to and on admission and identified any individual needs the patient may have to encourage them to live a healthier lifestyle. For example, we noted as part of the patient pre-assessment process, the patient could say if they had any additional needs or required additional support 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 and ensured that patients gave consent in a two-stage process with a cooling off period of at least 14 days between stages. They understood how to support patients.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. All staff we spoke with understood consent and the Mental Capacity Act (MCA) process and patient records demonstrated that staff had sought written consent prior to any treatment.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff knew about written and implied consent and that following any surgical procedures there may be times when a patient's mental capacity may fluctuate and how to manage this in line with the services consent and MCA policies.

The service met cosmetic surgery standards published by the Royal College of Surgeons (RCOS). For example, details in relation to a 14-day cooling off period was clearly referenced to RCOS in the services consent policy.

Nursing and clinical staff received and kept up to date with training in the and Deprivation of Liberty Safeguards (DoLS). Data supplied by the service showed staff achieved 100% compliance with MCA and DoLS training.

Are Surgery caring?

Good

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

Compassionate care

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

We observed staff being 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 spoke to one patient who told us that they had attended the service several times and that staff had treated them well and with kindness on each occasion, especially the surgeons.

Good

Surgery

We noted that staff closed patient privacy screens to promote dignity and privacy during any consultations or treatment.

Reception staff greeted visitors with kindness, and we observed all staff introduce themselves when they first met patients in the reception and staff knocking on doors or screens when they entered patient rooms to introduce themselves.

The services patient satisfaction survey from April 2022 showed that 100% of patients said they had been treated with respect and dignity. One patient feedback said, “Polite, courteous, friendly manner and informative.” Another patient said, “All staff that treated me were exceptional from start to finish.”

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. The patients preassessment process enabled staff to specifically identify and discuss any additional mental health needs so this could be reflected in the patients care pathway and ensure staff were aware of any additional needs.

Staff we spoke with understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs, 97.9% of staff had completed training in equality, diversity and inclusion.

Emotional support

Staff provided emotional support to patients to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We noted that the patient preassessment process enabled patients to share and discuss any concern they may have, for example needle phobia so that staff could provide the necessary support. One patient left feedback about the service which said, “The surgeon chatted to me when I told him I was nervous and visited me after surgery. All of the nurses that cared for me were amazing and so kind.”

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 we spoke with understood the importance of respecting a patient’s individual rights and choices. One member of staff told us that sometimes patients may be nervous when they arrive at the clinic and how reassuring them and involving them in decisions regarding their care often helped the patient to relax.

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 that staff spoke with patients in a way they could understand. The service had made reasonable adjustments to the environment, for example a hearing loop for patients with a hearing impairment to promote their involvement in their care and decisions and staff could also access translation services to encourage patient participation in decisions about their care.

The services patient satisfaction survey from April 2022 showed that 100% of patients answered yes when asked if they were involved as much as they wanted in decisions. One patient said “Thank you to all the team. Made me feel at ease at all times.” The patient satisfaction survey also showed that 88.9% of patients said they were 'Always' given all the information required before they left.

Good

Surgery

Patients and their families gave feedback on the service and their treatment and staff supported them to do this. The patients we spoke with told us they would speak up if they felt they had any concerns and knew the service had a complaints policy.

Patients gave positive feedback about the service this was supported by patient feedback collated by the service. Staff displayed feedback from patient surveys in prominent places within the environment.

Staff supported patients to make informed decisions about their care. The service had an up to date policy in relation to consent and there were opportunities during the patient reassessment processes for them to ask questions and seek more information in relation to their planned care and treatment.

Are Surgery responsive?

Good

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

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. There was a system for referring patients for psychological assessment before starting treatment, if necessary.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service had access to translation services.

The building was accessible including wide door openings, low level door handles, low level handwash basins and a hearing loop system for the hearing impaired.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Patients completed a request form for any meals when attending clinics and this was prepared off site and delivered for the patient. Staff could also make patient snacks from a dedicated kitchen on site and 95% of staff had completed food hygiene training.

The patient pre-assessment process gave staff the opportunity to review and discuss the patient's mental health and wellbeing prior to accessing any care or treatment. Staff also checked if the patient had any previous care or treatment and whether there were any concerns that the patient may not be emotionally or psychologically fit for surgery, this was also detailed within the services consent policy. Staff could escalate any concerns regarding a patient's mental health for discussion at the services the capacity and compacity meetings. These meetings enabled staff to discuss and review additional patient risks, and ensure the patient was safe and had full capacity to consent to treatment. Managers gave examples of when they had used these processes to safely manage patients who may be making unwise decisions, placing themselves at increased risk or who may need referral to other specialist service, for example mental health services.

Access and flow

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

Good

Surgery

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. As this was a demand led service, managers could plan resources based on demand and flow within the service. There were also effective processes in place to cover any staff changes due to absence, including ensuring a second anaesthetist was always available to cover any shortfall.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service carried out comprehensive risk assessments for all patients which determined their likely after care and worked with patients to ensure they were discharged from the service on time and safely.

Managers worked to keep the number of cancelled appointments/treatments/operations to a minimum. The service was demand led, and managers worked with patients and the booking team to respond to demands. Patients could make changes to their scheduled appointment, and managers liaised closely with patients and the bookings team to ensure resources were not wasted and the number of cancelled appointments were minimal. The service also provided regular fixed clinics for the consultants, regular fixed theatre slots, quick access to additional theatre sessions, an easy referral process by the patients named consultant and flexibility of appointments. Managers told us that cancellation of appointments was very rare due to the systems they used to manage bookings.

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 had a system for referring unresolved complaints for independent review.

Patients and relatives knew how to make a complaint or raise concerns. The complaints process was available on the service's web site and details on the complaints and feedback processes were clearly displayed in patient areas. In the main reception area, patients could use their smart phones to scan a poster which brought up a service review page for them to fill in and leave feedback on their patient experience.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with understood the service's complaints process and who to seek advice from when receiving a complaint. The service had received six formal complaints since October 2021, and staff had taken appropriate action to manage the complaints in line with the services time frames and applied duty of candour where necessary.

Managers shared patient feedback with the staff team and patient feedback on the service was also displayed in patient areas. Staff knew how to acknowledge complaints and told us they received feedback from managers after the investigation into their complaint and that managers used the daily huddle to feedback on any complaints received.

Managers investigated complaints and identified themes. The service's governance team had oversight of all complaints received within the service and the actions taken to resolve them. Managers shared feedback from complaints with staff and learning was used to improve the service. We reviewed complaints and found learning had been implemented based on patient feedback. For example, one patient had complained that reception staff had not asked security questions prior to providing feedback to a relative who was asking for an update on a patient. The service implemented additional security questions based on this feedback, which all reception staff had to ask when taking an external call.

Good

Surgery

The service subscribed to the Independent Sector Complaints Adjudication Service (ISCAS) and the services complaints process followed the ISCAS code for managing complaints including escalation to independent adjudication. The service held a formal complaint register which was regularly reviewed by the service executive board to ensure any areas of learning were addressed. At the time of our inspection the service had no open complaints with ISCAS.

Are Surgery well-led?

Good

This was our first inspection of the service. 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.

Leaders had the skills, knowledge and experience to run the service. The service was led by the chief executive officer (CEO) and a hospital director. At the time of our inspection the hospital director was in the process of registering with the Care Quality Commission (CQC) to become the registered manager and take on the day to day oversight and leadership of the service. This role was previously performed by the CEO, but given the different locations owned by the provider, the service deemed that a permanent registered manager at this location was appropriate to support ongoing developments and provide consistent leadership locally.

The hospital director had substantial experience in developing services, implementing change and monitoring safety and improvements within clinical services. They understood the challenges to quality and sustainability and knew the actions needed to address them, including plans to improve and expand services. The hospital director led a local management team that included the theatre manager, patient services manager, ward manager and the estates and facilities manager. The service had a qualified consultant surgeon as its responsible officer (RO). The RO was a senior clinician who ensured the doctors for whom they acted in this nominated capacity, continued to practice safely and were properly supported and managed in maintaining their professional standards.

There was clear and visible leadership within the service, all the staff we spoke with told us the senior and local management teams were approachable and very visible around the service. Senior staff operated an open-door policy and staff told us there were no barriers to communicating with the management team.

Vision and Strategy

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

The service had a vision which was, “To be one of the leading independent providers of healthcare; working in partnership with our medical professionals and patients, we offer individual and personal care. We make sure they feel 100% reassured, special and unique at every stage. We work in partnership with our doctors and medical teams to provide the care the doctors would choose for themselves, treating all our patients with compassion and kindness. strategies which

linked to the hospital's overall strategy." The vision was displayed in prominent areas of the hospital and on the services website. The service had a strategic plan, based on demands locally for an extension of services and providing opportunities for patients to access increased services at the location. The hospital director and senior team understood the vison and strategy and how to promote this in the service and to external stakeholders.

Staff we spoke with knew about the vision and this was displayed next to staff workstations. Staff told us the service had been through quite a lot of change, but the management team had kept them informed of the changes, why these were happening and how it may affect staff.

The service had a strategy aligned to local plans in the wider health and social care economy, and services had been planned to meet the needs of the relevant population. During the pandemic, the service had provided NHS support treating patients, outpatients and diagnostic imaging. Senior leaders told us that collaborative working with the NHS would continue as they already provided some services for NHS patients, for example podiatry services in outpatients.

Culture

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

Staff we spoke with felt respected and valued by the service and told us they were proud to work at the Phoenix Hospital. Staff told us that managers were approachable, staff were supportive, and they felt valued. The service encouraged internal development to support staff retention and increase morale, and staff had been promoted to more senior roles,

Leaders and staff understood the importance of being able to raise concerns without fear of reprisal. The culture encouraged openness and honesty at all levels within the organisation, including people who used services, and in response to incidents. Staff we spoke with told us they were encouraged to report all incidents as they were a learning opportunity. Staff confirmed they could raise any issues with their line manager or other senior staff on site.

The service had a member of staff dedicated as the Freedom to Speak Up Guardian (FTSUG), and posters displaying the staff member's name, photo and contact details were prominently displayed within the service. The FTSUG was an experienced and trained health care professional who had time allotted to manage any FTSU issues. Data supplied by the service showed staff achieved 90.3% compliance with speak up training, which was above the services 80% compliance target. Freedom to Speak Up Guardians support workers to speak up when they feel that they are unable to do so by other routes. They ensured that people who spoke up were thanked, that the issues they raised were responded to, and ensured the person speaking up received feedback on the actions taken. staff we spoke with were aware of the FTSUG.

Governance

Leaders operated effective governance processes throughout the service and with other 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.

Leaders operated effective governance processes throughout the service and with partner organisations. Governance arrangements were the responsibility of the providers board who delegated day to day management of the service and facilities to the chief executive, executive committee and hospital director. The executive committee included governance, quality and safety issues as a formal agenda item at their monthly meetings.

Good

Surgery

The board met every three months, and several key governance groups reported into the board in relation to safety, performance, patient experience and risk via the executive committee and local medical advisory committee (MAC). The executive committee reported directly to the board and met monthly to scrutinise reports and feedback from the health and safety committee, information governance committee, patient experience group, learning and development committee, capital expenditure and remuneration committee, and facilities meeting.

The service had a local MAC that met every three months and reported directly to the MAC at provider level, which covered the providers other locations too. The MAC received reports from the hospital director, clinical governance manager meeting, mortality and morbidity, cleaning contract working meeting, infection prevention and control audit action plan and working group, complexity and capacity and health and safety working group. We reviewed the governance meeting records from January 2022, which demonstrated that a wide range or performance and risk issues were discussed, key actions recorded to ensure any issues were dealt with and clear lines of accountability.

The head of operations had oversight of all service level agreements (SLAs). For example, SLAs for clinical waste and equipment maintenance, these were regularly reviewed with the estates and facilities manager, often weekly, to ensure services were being provided in line with the SLA and to get value from the SLA.

The service's MAC was an integral part of the governance structure. The purpose of the MAC was to advise the CEO, hospital director, head of clinical governance and risk and any other relevant staff on any matter relating to the proper, safe, efficient and ethical medical use of the services. The MAC consisted of the senior staff of the hospital such as the hospital director, medical director and other representatives from leadership team.

The MAC met four times a year to consider and provide advice on maintaining high clinical standards, assessment of the risks involved and ensuring continuous improvement in the quality of clinical care. The MAC reviewed incidents and root cause analyses, complaints and patient satisfaction and at the time of our inspection the leadership team had taken the decision to add mortality and morbidity to its MAC agenda. We reviewed MAC meeting records from October 2021 and February 2022, which covered a wide range of governance issues.

Mangers held daily safety huddles, to discuss safety issues, such as learning from incidents, and root cause analyses, complaints and safeguarding. They also covered incident and compliance training, and medicine updates, updates on policies and guidelines, quality and risk management.

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. We reviewed staff meeting records from March 2022 to May 2022 which demonstrated information regarding training, standards of care, medication and performance were discussed with the staff team.

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 service had an up to date risk register and staff and managers we spoke with were aware of what the risks were. Risks were rated based on their severity, had a review date and named individual responsible for oversight and mitigation of the risk. The risk register was reviewed by the governance and clinical lead on a weekly basis and contained key risks such as staffing levels, equipment renewals, and the formulation of a service level agreement with the local NHS trust for transfers out amongst other risks

The service had an up to date business continuity plan, and this clearly defined how to continue to manage the service if there were any unplanned disruptions, as well as roles and responsibilities in an emergency.

Information Management

The service collected reliable data and analysed it. The information systems were integrated and secure. The service submitted external notifications where appropriate.

The service collected reliable data and analysed it, this included audit data, patient outcomes data and information in relation to any risks within the service.

Patients were given clear advice on what information the service would collect and why. The service had a dedicated privacy statement that all patients could access on its website detailing why privacy was important and explaining how the patient's personal data was used.

Staff had enough access to information and challenged it when necessary. There were clear service performance measures, which were reported and monitored with effective arrangements to ensure that the information used to monitor, manage and report on quality and performance was accurate. When issues were identified, these were appropriately escalated in line with the services risk and governance processes for review and action.

The service liaised where appropriate with external monitors of care and submitted data to the National Breast Registry, National Confidential Enquiry into Patient Outcomes and Death, and the Private Healthcare Information Network.

The service had a Caldicott Guardian, who was a responsible for protecting the confidentiality of people's health and care information and to ensure it was used properly.

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 service offered a range of NHS services, as well as private and insurance-based patient options and was in discussions with local NHS and clinical commissioning groups regarding extending services as part of their strategic plans.

The service had a "rising stars" award that could be given to staff who were nominated for their achievements within the service.

Staff could access occupational health to help them with any health or wellbeing issues. The service also had a program called E-Hub where staff could contact and request help with financial advice or assistance, bereavement and mental health.

The service recently celebrated international nurses' day to recognition the contribution that nurses made within the service.

The service had a patient experience group to listen and learn from the views of patients and the service was developing a patient forum where they could directly listen to the views of patients.

Learning, continuous improvement and innovation

All staff were committed to improving services.

Good

Surgery

The service had a strong focus on sustainability, as well as recycling and looked for renewables where possible. They were in the process of replacing all lighting with low energy bulbs, and installing electric vehicle charging points to reduce their carbon footprint. They also participated in the big energy saving week during in January 2022. The big energy saving week is a national campaign to help people cut their fuel bills and get financial support.

Good

Outpatients

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

Are Outpatients safe?

Good

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

Mandatory training

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

Staff received and mostly kept up-to-date with their mandatory training. Staff completed training online and in person depending on the type of training. Staff completed mandatory training at induction, annually and also received updates when required. All staff completed 18 courses including fire prevention and awareness, health and safety awareness, general data protection regulation (GDPR), manual handling, infection control and basic life support (BLS).

Mandatory training was comprehensive and met the needs of patients and staff. Nurses were supported in achieving specialist mandatory training and completed 18 additional courses including care of the deteriorating patient where compliance was 100%, catheter care awareness (100%), Immediate life support (ILS) (100%), and sepsis awareness (89%).

Overall training compliance for outpatients was 91% which was above the hospital target of 80%.

Medical staff worked at the service under practising privileges. They completed mandatory training in their NHS job and provided evidence of completion at appropriate intervals to evidence compliance. Managers gathered evidence through an electronic database which alerted them by email when updates were required.

Nursing staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Compliance for disability awareness training was 100% and dementia awareness training was 89%.

Managers monitored mandatory training and alerted staff when they needed to update their training. The alert system meant that staff completed their training at regular intervals to support compliance.

The service was behind target for chaperone training (22%) and venous thromboembolism (VTE) training (49%). Managers told us they had identified a new chaperone trainer and chaperone training and competency sign-off had been arranged for all staff. A plan was also in place to increase compliance of VTE 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.Managers were trained to level 3 safeguarding adults and children and the service's safeguarding lead was trained to level 4, with good links to the local authority safeguarding team should they need additional support. Training was comprehensive and included female genital mutilation (FGM), modern slavery and honour based violence. Staff achieved 100% compliance with safeguarding adults' level 2 and 100% compliance with safeguarding children level 2, both were above the service compliance target of 80%.

Medical staff received training specific for their role on how to recognise and report abuse. Medical staff working under practising privileges provided evidence of compliance through their NHS annual appraisal and training records.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff completed equality, diversity and inclusion training; compliance was 100%.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff demonstrated a good understanding of safeguarding adults and children, including, how to identify those at risk of, or suffering harm from abuse or neglect. Staff could access an up to date safeguarding policy that outlined procedures for managing and dealing with safeguarding concerns.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. A safeguarding lead supported staff in identifying and raising safeguarding concerns, this helped with a consistent approach. Staff understood the processes to escalate safeguarding concerns to their manager or lead who acted in line with their local safeguarding policies and procedures.

The service did not provide any services for children and patients were encouraged not to bring children to appointments with them.

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.

A dedicated infection prevention control (IPC) nurse supported staff in ensuring good infection prevention control standards. Staff used an up to date infection control policy to help control infection risk and had access to the group IPC lead through a monthly IPC meeting.

Additional protocols that were updated in line with national guidance were in place in response to COVID-19. There were visible adaptations to the environment for example socially distanced seating in the waiting area. Staff, patients, and visitors who attended the hospital followed clearly defined instructions to limit the risk of cross infection, for example lateral flow testing, hand sanitising and personal protective equipment (PPE) to reduce cross infection.

Good

Outpatients

Staff followed infection control principles including the use of PPE. All staff completed mandatory infection control training and compliance was 100%. Nursing staff also completed infection control and sharps level two training; compliance was 89%.

The service generally performed well for cleanliness. Staff completed audits which included sharps, PPE, handwashing, clinical environment and uniforms to assess compliance. All audits reviewed showed 100% compliance.

Staff were able to give examples of how the service responded promptly to audit results, for example by installing apron holders to ensure aprons were readily available in the consulting rooms. Staff had identified that an examination bed needed to be recovered, this had been recorded on the incident recording system to be addressed by managers.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed 'I am clean' labels on equipment indicating the date last cleaned.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The service used contract cleaners to clean the facilities in the evening. Employed support staff maintained cleanliness throughout the day, cleaning touchpoints in reception and clinic rooms between consultations. We saw staff meeting minutes where the importance of cleaning was discussed.

Clinical areas were visibly clean and had suitable furnishings which were clean and well-maintained. However, the flooring within the five consulting rooms was partially carpeted. We raised this with managers who told us that replacement flooring was planned as part of the hospital capital expenditure plan.

Environment and equipment

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

The design of the environment followed national guidance. The hospital was on a single level and accessible to those with mobility aids. The reception area was staffed during opening hours to welcome patients and visitors, the desk included a lowered section for wheelchair users. The waiting room was large with adequate seating a refreshment area and regular and disabled toilet facilities. There was adequate free car parking for visitors and staff.

There were five consultation rooms and a treatment room used for minor operations. There was a dedicated preassessment room, a clinic room where nurses attended to patient dressings and storage areas.

The building was wheelchair accessible and included wide door openings, low level door handles and low level handwash basins. There was also a hearing loop system for people living with a hearing impairment.

Patients could reach call bells and staff responded quickly when called. All clinic rooms were fitted with emergency call bells. Toilets were fitted with call bells and pull cords.

Staff carried out daily safety checks of specialist equipment. All electrical equipment was tested annually, all equipment checked was in-date. Staff told us they reported faulty equipment on the incident reporting system and moved any equipment waiting to be repaired out of use.

The service had suitable facilities to meet the needs of patients' families. There were two disabled toilets, with baby changing facilities. The service had recently revised the COVID-19 policy to enable patients to have one companion with them; however, the companion was required to provide two negative lateral flow tests.

The service had enough suitable equipment to help them to safely care for patients. Staff could easily access resuscitation equipment across all areas. All staff understood their responsibilities in completing equipment checks. Staff tested the Automated External Defibrillator **(**AED) daily and checked the contents of the resuscitation grab bag weekly.

The service used single use consumables, any equipment requiring decontamination was sent off-site for decontamination under a service level agreement (SLA).

Staff disposed of clinical waste safely. Waste was safely stored, labelled, and removed from clinical areas at regular intervals. Sharps bins were appropriately located, labelled and not overfilled.

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. Patients attending for outpatient appointments were generally fit which meant they did not routinely have clinical observations performed. However, where observations were required, we saw appropriately completed evidence-based assessments and observation forms.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used the National Early Warning Score (NEWS2) tool to monitor clinical observations. Patients who required an assessment were reviewed and baseline clinical observations completed. These observations included blood pressure, heart rate and temperature. These were used to inform decisions made about the patient's clinical condition and to plan their treatment.

The service had made improvements to the layout of the NEWS2 chart to include the patient pain score alongside the escalation question. Managers told us this was implemented in early 2021 following staff training and would form part of a new admission booklet from June 2022 onwards.

Staff received NEWS2 training as part of their induction to clinical documentation and initially worked supernumerary under clinical supervision. New starters were assessed before being signed off and allowed to work unsupervised. NEWS2 training compliance for clinical staff was 100%.

Staff knew about and dealt with any specific risk issues. Staff completed risk assessment tools to identify and reduce risk. For example, patients with a medical history of blood clots were assessed for anticoagulant therapy to prevent reoccurrence post treatment. Venous thromboembolism (VTE) assessments were completed on all patients as part of the preparation for surgery.

Staff shared key information to keep patients safe when handing over their care to others. Following patient appointments, information was shared with those responsible for completing the patient's care pathway. Patient notes were clear with detailed discussions and clinical findings. Patient notes were held centrally and securely in portable trolleys which meant they could be transported securely to different departments.

Shift changes and handovers included all necessary key information to keep patients safe. Key staff attended weekly complexity and capacity meetings to ensure that any risks had been identified and addressed, for example, patients who needed to stop medication before procedure, had been correctly briefed, specialist equipment had been ordered and received.

The service did not have access to mental health liaison and specialist mental health support. Patients with known mental health conditions were not routinely referred to the hospital. However, preassessment prompts included memory loss questions to allow staff to identify and support patients living with dementia. Nurses completed mental health awareness as part of mandatory training, compliance was 88.9%.

Staffing

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 with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment, however the service was reliant on bank staff to do this.

The service had enough nursing and support staff to keep patients safe. Nursing staff worked flexibly across outpatients, preassessment and the ward.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance. Managers told us the service was growing, and additional staff were being recruited to meet the increasing demand. They planned to have separate dedicated teams covering the three clinical areas in the future.

Clinics were planned alongside staffing requirements to ensure the correct staffing was available to meet the needs of patients. Staff shared clinic and patient activity at the daily safety and planning meeting each morning.

The manager could adjust staffing levels daily according to the needs of patients. Managers had access to a team of regular bank workers who were familiar with the service for continuity and safety.

The service had low and/or reducing turnover rates. The service had experienced high turnover of staff in November and December 2021 however the yearly average was low at 4%. Managers were recruiting to achieve planned numbers.

The service had low sickness rates of 0.32% for nurses and 0.3% for health care assistants (HCA).

Managers limited their use of agency staff and requested staff familiar with the service. The outpatient service had not used agency staff in the six months before our inspection.

Managers made sure all bank and agency staff had a full induction and understood the service. Bank staff were given time to complete mandatory training and a two week induction.

The number of nurses and healthcare assistants matched the planned numbers; however, the service was reliant on bank staff to do this. Managers told us that new staff had been appointed and more recruitment was planned. They had recorded reliance on bank and agency staff as a risk on the service risk register.

Good

Outpatients

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The hospital director managed the recruitment and ongoing compliance monitoring process of consultants who worked at the hospital under practising privileges. Consultants completed a detailed application and provided evidence of medical indemnity, clinical scope of practice, General Medical Council (GMC) registration, Information Commissioners Office (ICO) registration, enhanced Disclosure and Barring Services (DBS), references, NHS appraisal and immunisation status. Appointments were approved by the Medical Advisory Committee (MAC). Managers monitored ongoing compliance, including biennial reviews, training and revalidation using an electronic database.

The service had enough medical staff to keep patients safe. Consultations were arranged according to the consultant's availability. The booking team liaised with medical secretaries to plan clinics and appointments.

The medical staff matched the planned number. Managers told us that consultant numbers were enough to meet patient demand. They did however hope to expand the range of specialisms available at the hospital, for example adding orthopaedics and ear nose and throat (ENT) clinics in the future.

Staff were able to contact consultants as necessary, including during evenings and weekends.

Records

Staff kept detailed records of patients' care and treatment if they had a minor or surgical procedure. Records were generally clear, up-to-date, stored securely and easily available to all staff providing care. However, the service did not keep records for patients who attended outpatient consultation only.

Staff stored records for patients who had recently undergone or were due to undergo minor operations in a clinical room to allow staff to complete pre and post procedure telephone calls and pre-assessment sign-off. Access to the room was restricted to appropriate staff by a digital combination lock.

Records for patients whose episode of care had ended were stored securely in locked cabinets and only those with permission could access them. Managers told us that the service was sourcing additional external storage to meet increasing demand.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff told us that the patient notes followed the patient through the pathway.

The service kept records for patients who had pre-assessment and a minor procedure or surgery. The record included the GP referral or confirmation of self-referral, clinic letter including planned procedure, registration form, pre-assessment paperwork, including risk assessments and paperwork to be completed during the procedure and in recovery. Records were comprehensive, and all staff could access them easily. However, the service did not keep records for patients who attended outpatient consultation only. These were held by the individual consultants who were registered as data controllers with the information commissioner's office (ICO). We raised this with managers who told us that they had a plan in place to retain outpatient records for all patients.

Records were generally clear and up-to-date. We reviewed 10 sets of patient records and found nursing documentation comprehensive however, consultant documentation was inconsistent, for example the venous thromboembolism (VTE) risk assessment was not always completed. We raised this with managers who told us that they were introducing a single pathway booklet to reduce the amount of duplication and improve documentation compliance.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff knew how to access medicines advice and supplies. Pharmacy support was provided by the group lead pharmacist and there were arrangements for out of hours support.

Staff completed medicines records accurately and kept them up-to-date. We reviewed 10 medication administration records and found all doses of administered medication had been signed and dated, allergies were documented, and weight was recorded where medication was prescribed according to weight. All records were legible.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. The patient satisfaction survey from September 2021 to April 2022 reported that on average 93% of patients said they were given advice on medication side effects.

The ordering, storage and administration of controlled drugs (CDs) was in accordance with the Misuse of Drugs Act 1971 and the associated regulations. Controlled drugs are drugs that are subject to strict government control because they may cause addiction or be misused. CDs were stored in fixed lockable cupboards, receipt, administration and destruction of CDs were correctly recorded in a CD register and access was restricted to registered staff. We reviewed the CD register and found entries complete and appropriately signed. The hospital director was the accountable officer for CDs (CDAO).

Staff completed medication awareness training; compliance was 89% which was above the 80% target. They learned from safety alerts and incidents to improve practice. Managers shared safety alerts with staff at the daily safety and planning meeting.

The group pharmacy lead completed medication audits and shared recommendations with managers and the wider staff team to ensure good practice. Managers told us they were waiting to receive the most recent audit report from the audit completed on 26 May 2022.

Staff stored and managed all medicines and prescribing documents safely. Prescriptions were stored securely and restricted to appropriate staff. Nurses signed five prescriptions out to a consultant at the start of a clinic and any unused prescriptions were signed back in at the end of the clinic. We reviewed the reconciliation log which confirmed that all prescriptions had been accounted for.

Medication was stored in a lockable cupboard and only authorised staff had access. We checked a sample of medication and all were within expiry date. The service had an organised process for patient take home medication.

Refrigerated medication was stored appropriately in lockable fridges and staff consistently recorded fridge temperatures. Staff told us there was an escalation process in place if temperatures were outside range. However, staff

had not consistently carried out daily ambient room temperature checks in areas where medications were stored. The ambient temperature range was also not specified on the recording document to prompt staff when ambient temperatures went out of range. We raised this with managers who told us they would take immediate action to update documentation and discuss with staff to ensure consistent checking.

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 used an accessible electronic reporting tool to report incidents and near misses. All staff we spoke with were able to tell us the type of incidents they would report, for example surgical site infections, return to theatre, unplanned readmission, slips, trips and falls. Data provided by the service showed that incidents were reviewed and investigated in a timely manner.

Staff raised concerns and reported incidents and near misses in line with the service's policy. The service reported 45 clinical and 13 non-clinical incidents from May 2021 to May 2022. Incidents were reviewed by the head of governance and risk and hospital management team; heat maps were created, and action plans were implemented to address shortfalls and identify learnings. Outpatient staff reported nine incidents in total, seven related to documentation incidents one related to clinic overrun and one related to a consultant not bare below the elbows.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff we spoke with were able to explain their responsibilities. Managers told us they had reported a subcontractor for an information governance breach. They were open and honest with patients affected and provided assurance that appropriate action had been taken to rectify the breach. Staff completed duty of candour training; compliance was 100%.

Staff reported serious incidents clearly and in line with the service's policy. We reviewed serious incidents and noted staff had reported these in a timely way. Staff we spoke with told us there was a safety culture in the service and that learning from incidents was shared with them including any actions necessary to stop any further incidents.

Staff received feedback from the investigation of incidents, both internal and external to the service. Managers met daily at the daily safety and planning meeting and discussed reported incidents. These discussions were shared with staff by email immediately after the meeting.

Managers investigated incidents thoroughly. Staff, patients and their families were involved in these investigations.

Staff met to discuss the feedback and look at improvements to patient care. Staff attended meetings where they discussed incidents and lessons learned to help them to make improvements to the service.

There was evidence that changes had been made as a result of feedback. Managers told us of a “near miss” where medications meant for “regular” administration had been recorded in error on the “as required” section of the medication chart. The service was redesigning their medication chart to align with the NHS, to reduce future risk of similar error.

Good

Outpatients

Are Outpatients effective?

Inspected but not rated

We have not previously inspected outpatients as a single service. We do not currently 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. 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. We reviewed a selection of policies including pharmacy provision, consent, medical records, preassessment, safeguarding children and vulnerable adults and medicines administration policy and saw that they were clear and accessible to all staff.

There was a process in place for policies to be reviewed regularly to ensure they were updated in line with national guidance, for example that provided by the Royal College of Surgeons (RCS) and National Institute for Health and Care Excellence (NICE).

Managers localised corporate policies and shared with the wider management team at the hospital management team meeting. Staff received policy updates by email and at the daily safety and planning meeting and staff meetings. We saw that the service had updated a policy following our inspection to address the lack of outpatient consultation documentation held.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff completed training in mental health awareness and the Mental Capacity Act (MCA) with deprivation of liberty safeguards (DoLS), compliance was 89% and 100% respectively.

The service met the Royal College of Surgeons (RCOS) professional standards in that the requirement for a 2-stage consent and patients to be given a 14-day cooling off period was clearly referenced in the consent policy.

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

The service had a robust audit programme which reviewed staff compliance with policy, this included hand hygiene, sharps, infection control/environmental audits, medical records audits, consent, resuscitation, surgical site infection and adhoc audits based on incidents. Any areas identified as needing additional training or compliance were addressed by the hospital manager.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink. Including those with specialist nutrition and hydration needs. Patients were informed of any dietary requirements before attending the service for a procedure. We saw that patients who attended pre-assessment were informed of the need to fast before attending for a procedure. Fasting guidance was in line with NICE guidance NG180, preoperative care in adults. Staff informed patients to fast for six hours unless advised differently by their consultant and patients could drink water up to two hours before any procedure.

All patients who received treatments were required to eat and drink before leaving the hospital and given advice on dietary needs following procedure. Patients meal orders were taken at preassessment and freshly prepared on the day. Vegan, vegetarian, gluten free diets and allergies could all be accommodated.

Staff did not use a malnutrition universal screening tool (MUST). However, patients underwent a preassessment where the patient's body mass index (BMI) was calculated and any concerns would be addressed.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

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

Patient records demonstrated that pain management was discussed. However, pain relief was not routinely given in the outpatient department unless patients were undergoing a procedure where pain relief was indicated.

Patient outcomes

The service had only recently started to monitor the effectiveness of care and treatment. Auditing of patient outcomes was not embedded.

The service participated in relevant national clinical audits, but this was not embedded. Mangers were engaging with The Private Healthcare Information Network (PHIN) to publish clinical outcomes. PHIN is the independent, government-mandated organisation publishing performance and fees information about private consultants and hospitals.

The service told us that a venous thromboembolism (VTE) audit had been developed and was in the process of being rolled out. However, this had not commenced.

Outcomes for patients were positive, consistent and met expectations. The service measured this through patient satisfaction surveys and reviews. The patient satisfaction survey from September 2021 to April 2022 reported that on average 100% of patients said the hospital met or exceeded expectations and 100% were likely to recommend.

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. We saw that staff had received role specific training to ensure that they were able to complete their roles. Competency assessments were completed either in house or by peers and external manufacturers.

Managers gave all new staff a full induction tailored to their role before they started work. The service arranged a two week service orientation to ensure staff were familiar with the environment and processes used by the service. They were also given protected time to complete mandatory training.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff told us they received an appraisal and managers provided documentation to show appraisal compliance was 100%. This meant all outpatient staff had a meaningful appraisal to help them improve performance. For example, identifying gaps in knowledge and skills and supporting training opportunities to improve standards of care for patients.

Managers made sure staff received any specialist training for their role. We reviewed training compliance which showed that 100% of staff had completed the care certificate (Standard 14: handling information) training and the care of the deteriorating patient workshop.

Medical staff competency was reviewed by peers as part of the General Medical Council (GMC) revalidation process. This included a review of training completed, feedback from learning and a 360-degree review from peers. Treatments and feedback from patients were also reviewed as part of the revalidation process. The service requested up to date annual NHS appraisals and training evidence for medical staff on expiry.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. If a new treatment was planned to be introduced, the practice was researched before implementation and staff received training. The service planned to introduce a new pain relief patch. The services had liaised directly with the manufacturer to arrange training for all staff who would be involved with this new technique. This ensured that staff were learning directly from the original source to ensure competence. Nursing staff told us additional 'hands-on' practical experience was planned for staff at the local NHS trust.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Meeting records demonstrated good attendance by staff. The service completed notes from meetings, which were shared with the team electronically.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff attended daily safety and planning meetings and told us consultants were easy to contact and conversations occurred daily.

Staff from each department met weekly at "capacity and complexity" meetings to discuss patients and plan their care. They used a standard agenda for consistency and shared minutes with staff who were not able to attend.

Patients could see all the health professionals involved in their care at one-stop clinics. Patients could attend their appointment and at the same time have further tests. For example, blood tests and swabbing to prevent repeated attendances.

Staff worked across health care disciplines and with other agencies when required to care for patients. Where necessary the team consulted with other specialties. We were given examples, of patients being referred to acute inpatient hospitals for ongoing review or treatments unable to be provided due to the predominant day case nature of the hospital.

Good

Outpatients

Seven-day services

Patients could contact the service seven days a week for advice and support after their surgery.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests. The service was available Monday to Friday 8am to 7pm and had a dedicated 24 hour nurse-led helpline for any patients needing additional advice outside of these hours.

Staff informed patients of any post treatment care and how to escalate any concerns in and out of hours before discharge.

The patient satisfaction survey from September 2021 to April 2022 reported that on average 92% of people received all the information required before leaving the hospital and 99% were provided with advice on who to contact after leaving the hospital if they had concerns.

Health promotion

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

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

Staff were prompted by the patient care pathway to provide this support during the preassessment.

The service did not use printed patient information to promote for example alcohol awareness and stopping smoking, however they did refer patients to appropriate NHS resources. Managers told us that patient information leaflets had been removed in line with COVID-19 guidance, and the service was considering the reintroduction.

Medical staff provided one-stop well-woman and well-man checks for patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff used a triplicate consent form which had enough space for the consultant to clearly document the planned procedure/s, intended benefits, material risks and alternative treatments.

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

Staff clearly recorded consent in the patients' records. We reviewed 10 patient records and found that consent was obtained in accordance with hospital policy.

Patients who were booked for cosmetic surgery were given a two-week cooling off period before undergoing the procedure. This enabled them time to change their mind if they wished. This was in line with national guidance.

Good

Outpatients

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Staff were aware of their responsibilities to take all reasonable steps to support a patient in making their own decision.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. They completed the Mental Capacity Act (MCA) with Deprivation of Liberty Safeguards (DoLS) training, compliance was 100%.

Are Outpatients caring?

Good

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed interactions between staff and patients and saw that they were respectful friendly and considerate.

Patients said staff treated them well and with kindness. We saw 17 reviews about the service and found that 15 were positive, patients confirmed that they had been treated well and that staff had been caring, professional and understanding.

Staff followed policy to keep patient care and treatment confidential. All patients were escorted into consultation rooms to discuss treatments which prevented discussions in communal areas. We observed that staff used 'engaged' signs on consulting room doors and knocked before entering.

All consulting rooms had privacy screens and notices promoting the use of chaperones.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. For example, the consent form specifically considered patients who for religious / cultural beliefs did not wish to receive any blood or blood products.

The patient satisfaction survey from September 2021 to April 2022 reported that on average 100% of people said that staff treated them with respect and dignity, 97% said they were given privacy to discuss their condition/ treatment.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw patient reviews where patients reported that staff helped them to feel "relaxed, comfortable and at ease". They said, "staff went above and beyond to make sure they were okay".

Staff told us how they would demonstrate empathy when having difficult conversations. Due to the nature of the service it was not common for patients to receive bad news. If necessary, consultants would break bad news themselves. Nursing staff were available to accompany doctors when holding difficult conversations to provide additional support to patients.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Medical staff gave patients, emotional support and advice when they needed it. We saw patients feedback relating to how staff had supported them to make decisions about realistic outcomes to manage their conditions.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients had been discouraged from bringing companions with them to their appointments due to COVID-19. However, staff considered each patient individually and made exemptions for those with recognised anxieties. The service had recently changed policy to permit one companions who had demonstrated two negative lateral flow tests.

Staff told us of an example where off-duty nurses had gained permission from managers to come in to work over the weekend to provide support and clinical advice to an anxious patient.

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 told us they clearly discussed treatment with patients and their relatives. Staff could extend appointments to ensure additional time was given if needed to explain things further. The service allowed an hour for preassessment appointments to give adequate time to answer patient questions.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We reviewed patient information and found it easy to understand, for example post-operative instructions for the use of anti-embolism stockings to reduce the risk of deep vein thrombosis (DVT).

Staff supported patients to make informed decisions about their care. Staff talked with patients in a way they could understand, using communication aids where necessary. We saw that staff spoke clearly and checked understanding.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service had an independently monitored patient satisfaction survey, in addition to patient's being able to leave feedback on the website and social media platforms.

Patient feedback was shared at meetings and used to make improvements to the service. For example, the service had introduced additional cold meal options following patient feedback that meal choice was limited.

Patients gave positive feedback about the service. The patient survey from September 2021 to April 2022 showed that on average 88% of people who completed the survey would recommend the hospital, 86% were satisfied with the quality of care and 100% said the hospital met their expectations and that they would return.

Good

Outpatients

The survey asked specifically about people's understanding and involvement in decisions. An average of 95% of people said they were involved in decisions about their care, 98% said their consultant explained things in a way they could understand and 95% said nurses answered questions in a way they could understand.

Managers were aware that participation in the survey was low with an average of 9 patients a month giving feedback this way. They told us they wanted to increase response rate and had started to ask patients to complete the survey at the follow up appointment which allowed patients more time.

Are Outpatients responsive?

Good

This was our first inspection of the service. We rated it 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 service was predominantly cosmetic surgery, with some general surgery, pain management and podiatry. Mangers told us the service was able to respond flexibly to changes in patient demand.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. Patients attending outpatient consultations could also have blood tests or minor procedures undertaken.

Facilities and premises were appropriate for the services being delivered. Patients had access to suitably equipped consulting rooms a minor treatment room and a comfortable seating area with refreshments.

Managers monitored and took action to minimise missed appointments. The service reported a low cancellation rate and monitored these through the daily safety and planning meeting. Staff used shared outlook calendars to make sure cancellations were promptly communicated to all staff involved in planning the patient care pathway.

Managers ensured that patients who did not attend appointments were contacted. When patients missed an appointment, the team contacted them to understand the reason for the cancellation and offer a convenient alternative. The service collected data to monitor and address any trends.

The service relieved pressure on other departments when they could treat patients in a day. Patients attending cardiac clinics to help identify cardiology conditions could be offered uninterrupted monitoring through a minimally invasive portable electrocardiogram (ECG) device worn for up to 14 days. This prevented them from having to return to the hospital each day.

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.

Good

Outpatients

Staff supported patients living with dementia and learning disabilities. Staff received training on disability awareness, dementia and mental health awareness, compliance was 89%.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service had a hearing loop at main reception.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to online and telephone interpretation services in languages spoken by the patients and local community.

The hospital was accessible to wheelchair users and patients attending with mobility aids. There were disabled toilets and ample disabled parking close to the entrance.

Access and flow

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

Managers made sure patients could access services when needed and received treatment within agreed timeframes. The service ensured that patients had easy access to appointments at times that suited them. Regular fixed consultant clinics were in place and additional clinics could be arranged quickly if needed. Patient's booked appointments through a quick, easy referral process managed by the consultant's medical secretary.

Managers worked to keep the number of cancelled appointments/treatments to a minimum. The service experienced low levels of cancellations as patients were able to book appointments at a time that suited them.

When patients had their appointments/treatments cancelled at the last minute, managers made sure they were rearranged as soon as possible.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service performed most procedures in outpatients or as a day case.

Managers and staff started planning each patient's discharge as early as possible at the pre-assessment stage.

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 displayed information on how to make complaints and actively encouraged patient feedback throughout hospital patient areas and on the provider website.

The service clearly displayed information about how to raise a concern in patient areas. Hard copy patient information leaflets were available at reception and in clinic rooms. Information was also available to download from the provider's website. The provider encouraged patients to complete online reviews and made this easy to do with helpful barcoded posters located in patient areas.

Good

Outpatients

Staff understood the policy on complaints and knew how to handle them. The service encouraged patients to try to resolve complaints informally by speaking to a member of staff. If staff were unable to resolve the complaint informally, they directed patients to the formal complaints process.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Local managers acknowledged, investigated and responded to stage one complaints. Patients who remained dissatisfied were directed to raise a stage two complaint with the chief executive officer (CEO). Any patient still unhappy with the response at stage two, could complain to the Independent Sector Complaints Adjudicator (ISCAS).

The service had received five formal stage one complaints from October 2021 to March 2022. All were acknowledged within two working days and concluded within 20 working days, in accordance with the provider complaints policy. At the time of our inspection the provider had one open complaint which had been acknowledged and was being investigated. No complaints had been referred to ISCAS. The patient services manager who was responsible for managing complaints had completed ISCAS training.

Managers investigated complaints and identified themes. The service did not receive a high number of complaints, however themes included communication and administration.

Staff could give examples of how they used patient feedback to improve daily practice. For example, the service had increased regular consultant clinics and streamlined referral process to reduce administrative delays.

Managers shared feedback from complaints with staff and learning was used to improve the service. We saw an examples of patient feedback which had resulted in change, for example, a patient had complained of being too cold to sleep comfortably. Staff attempted but were unable to adjust the temperature of the room. The provider subsequently identified a fault and repaired the air handling unit (AHU).

Are Outpatients well-led?

Good

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

Leadership

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

Leaders had the skills and abilities to run the service. The hospitals director led a local management team that included the theatre manager, patient services manager, outpatients/ ward manager and the estates and facilities manager.

The outpatient/ward manager worked closely with the patient services manager and theatre manager and provided direct departmental leadership to outpatients.

The service had a qualified consultant surgeon as its responsible officer (RO). The RO is a senior clinician whose role is to ensure that the doctors continue to practice safely and are properly supported and managed in maintaining their professional standards.

The service was further supported by a quality and risk perspective by the head of clinical governance and risk.

Leaders understood and managed the priorities and issues the service faced. The manager valued the committed team of staff who worked flexibly across outpatients and the ward. With the stable growth in business they planned to invest in staff by developing subject specialty teams to improve the patient experience, for example having a dedicated team of preassessment nurses.

Managers were visible and approachable in the service for patients and staff. Staff told us the leadership team were visible and approachable. Staff and leaders displayed respectful and friendly interactions. Senior staff operated an open-door policy and staff told us there were no barriers to communicating with the management team.

Staff told us they felt supported by senior leaders and the improved governance focus. We saw a reasonably new, engaged leadership team who were working cohesively to deliver improvements to the service and sustainable care.

They supported staff to develop their skills and take on more senior roles. Managers completed appraisals with staff and used these to identify development opportunities. All staff who had been employed for more than a year had received an appraisal in the last year.

Vision and Strategy

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

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The service had a vision which was, “To be one of the leading independent providers of healthcare; working in partnership with our medical professionals and patients, offering individualised and personal care. Making sure patients feel 100% reassured, special and unique at every stage.”

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The vision was displayed around the hospital and on the service website. The service had a strategic plan, based on demands locally to extend the service provision for patients by the addition of new specialties and improved diagnostic capability.

Leaders and staff understood and knew how to apply them and monitor progress. The hospital performance against plan was discussed openly at the daily safety and planning meeting, attended by a representative from each department.

During the pandemic, the service supported NHS colleagues to ensure that patients requiring urgent and time critical treatment did not have to wait for treatment, for example by supporting with skin cancer clinics and procedures. The service had continued to collaborate with the NHS for example by providing podiatry services to NHS patients.

Culture

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

Good

Outpatients

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff we spoke with felt respected and valued by the service and told us they were proud to work at Phoenix Hospital and enjoyed their work. The service ran a reward and recognition initiative where staff could nominate colleagues for outstanding work. We observed the daily safety and planning meeting where staff received 'shoutouts' for best practice.

The service promoted equality and diversity in daily work and provided opportunities for career development. Managers we spoke with were keen to support staff to develop. They felt proud of the strong teamworking culture.

The service had an open culture where patients, their families and staff could raise concerns without fear. Staff we spoke with told us they were encouraged to report all incidents. They confirmed they could raise any issues with their line manager or other senior staff on site.

Staff had access to a dedicated Freedom to Speak Up Guardian (FTSU), and posters displaying the name, photo and contact details were prominently displayed.

The service provided "Speak Up" training for staff and "Listen Up" training for managers, outpatient compliance for both was 100%.

Staff had access to a Caldicott Guardian, who was responsible for protecting the confidentiality of people's health and care information and making sure it is used properly, staff we spoke with were all aware of these services.

Governance

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

Leaders operated effective governance processes, throughout the service and with partner organisations. Governance arrangements were the responsibility of the board of directors who delegated day to day management of the service to the chief executive officer (CEO), executive committee and hospital director (HD).

The executive committee met monthly and discussed governance, quality, health and safety and risk as standard agenda items. This committee fed into the quarterly (three-monthly) board meeting. Several committees including the health and safety, information governance, capital expenditure and patient experience committee fed into the monthly executive meeting.

The Phoenix Hospital medical advisory committee (MAC) met every three months, they reported into the provider MAC. They comprised of the hospital director, medical director, senior managers and one or more consultant representatives from each speciality. They received reports from the hospital director and head of clinical governance and risk as well as from working groups including clinical governance, mortality and morbidity, contract cleaning, infection prevention and control, complexity and capacity and health and safety.

The hospital MAC was an integral part of the service governance structure. The purpose of the MAC was to advise the CEO, hospital director, head of clinical governance and risk and management team on matters relating to the proper, safe, efficient and ethical medical use of the hospital.

We reviewed minutes which demonstrated this committee had oversight of patient satisfaction, service incidents, complaints and risks as well as having input into consultant practising privileges decisions and business decisions that could impact on patient safety.

The group head of operations had oversight of all service level agreements (SLA). For example, clinical waste, decontamination and equipment maintenance. These were regularly reviewed with the estates and facilities manager, to ensure services were provided in line with the agreement and represented value for money.

Staff attended a daily safety and planning meeting where they reported and discussed safety issues, such as resuscitation and fire marshal arrangements, learning from incidents, complaints and safeguarding concerns. The meeting was minuted and shared by email with all staff and included safety alerts, medicine updates, mandatory training compliance and updates on policies and procedures.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff attended departmental meetings. Clinical staff from outpatients and the ward met regularly, as did reception and administration staff. Staff were invited to ask questions and share ideas. The minutes were accessible to staff who were not able to attend.

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.

Leaders and teams used systems to manage performance effectively.

The service had an up to date risk register and staff and managers we spoke with were aware of service risks. Risks were rated based on severity, had a review date and a named individual responsible for oversight and mitigation of the risk. The hospital director and head of clinical governance and risk had oversight of all risks and regularly reviewed risks.

Managers identified and escalated relevant risks and issues and identified actions to reduce their impact. Service risks include reliance on bank and agency staff, lack of formal service level agreement (SLA) with the NHS for emergency transfer of patients, lack of emergency bloods on site, frequent failure of air handling unit (AHU)/ business management system (BMS) and lack of advanced life support (ALS) trained nursing staff.

The service had plans to cope with unexpected events. The outpatient service had an up to date business continuity plan, and this clearly defined how to continue to manage the service if there were any unplanned disruptions, as well as roles and responsibilities in an emergency. Examples of unexpected events included loss of water, electricity and severe weather.

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 collected reliable data and analysed it. Managers used an electronic risk management system to collect and analyse incidents and identify themes, an electronic database to manage documentation for consultants with practising privileges and a range of financial reporting tools to monitor the service performance.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Managers used a dashboard to measure performance against key performance indicators (KPIs). Daily activity, incident and complaint performance was collected at the daily safety and planning meeting and communicated by email to all staff.

The information systems were integrated and secure. The service used an integrated secure electronic patient administration system (PAS) to manage patient appointments and procedures. Information was accessed using secure logins and staff were aware of their responsibilities under the general data protection regulations (GDPR). Staff completed GDPR training and compliance was 100%. Consultants were registered with the information commissioner's office (ICO) as data controllers and were responsible for keeping patient information secure if taken off-site.

Patients were given clear advice on what information the service would collect and why. The service had a dedicated privacy statement that patients could access on the website detailing why privacy is important and explaining how the patient's personal data was used.

Data or notifications were consistently submitted to external organisations as required. The service liaised where appropriate with external organisations and submitted data to the National Breast Registry, National Confidential Enquiry into Patient Outcomes and Death (NCEPOD), and the Private Healthcare Information Network (PHIN).

Managers understood their responsibility to report information breaches to the Information Commissioner's Office (ICO). The service had internally reported an information governance incident in the last six months, but this had not met the threshold for reporting to the ICO.

The service collected reliable data and analysed it, this included audit data, patient outcomes data and information in relation to any risks within the service.

Patients were given clear advice on what information the service would collect and why. The service had a dedicated privacy statement that patients could access on the website detailing why privacy is important and explaining how the patient's personal data was used.

Engagement

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

Leaders actively collaborated with partner organisations to help improve services for patients. The service offered a range of self-funding services, as well as insurance-based patient options and was in discussions with local NHS trusts and clinical commissioning groups (CCGs) regarding extending services for NHS patients as part of their strategic plan.

They openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. Staff could access occupational health to help them with health or wellbeing issues. The service also had a program called E-Hub where the staff could request help with finances, bereavement and mental health.

The service celebrated international nurses' day to recognise the contribution that nurses made within the service.

Good

Outpatients

The service had a patient experience group to listen and learn from the views of patients and the service was developing a patient forum where they could directly listen to the views of patients.

The service had developed a staff satisfaction survey which they planned to launch in June 2022.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

All staff were committed to continually learning and improving services. The service had recently introduced a consultant led aesthetic multi-disciplinary meeting where consultants were invited to discuss and learn from interesting case studies.

Leaders encouraged innovation and participation in research. The service focused on sustainability and were in the process of replacing lighting with low energy bulbs and installing electric vehicle charging points to reduce their carbon footprint. They participated in the big energy saving week in January 2022 which was a national campaign to help people cut their fuel bills and get financial support.