Nuffield Health

Nuffield Health The Manor Hospital Oxford

Inspection report

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Date of inspection visit: 22 and 23 March 2022
Date of publication: 17/06/2022

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

- The overall rating for this hospital remained the same, we rated it good.
- The hospital had enough staff to care for patients and keep them safe. Staff across services assessed risks to patients, acted on them and kept good care records. The service managed incidents well and learned lessons from them. Services across the hospital were visibly clean.
- 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 services. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff across all services treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. Staff in services for children and young people had an outstanding culture of providing care and treatment, especially emotional support for patients with phobias and learning disabilities.
- Services across the hospital planned care to meet the needs of the communities it served, 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 procedures. Services for children and young people provided outstanding support for LGTBQIA2S+ patients.
- Leaders ran services well and 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.

However

- At the 2016 inspection, outpatients and diagnostic imaging were rated together. At this inspection we rated them as separate core services. The rating for diagnostic imaging went down to requires improvement. In response we have served two requirement notices, one for safe care and treatment and another for good governance.
- The hospital had carpets in clinical areas across services. This was reported in the 2016 CQC report, and was preventing the endoscopy service from being accredited. Although the pace of change was slow, there were good infection prevention and control practices in place to keep patients safe until the refurbishment was completed.
- Staff in the surgery, outpatient and diagnostic imaging departments did not have key skills, including understanding how to protect patients from abuse. Mandatory training completion rates for these departments was below the hospitals target, including safeguarding adults and children.
- Staff in the diagnostic imaging department did not always control infection risk well. Personal protective equipment was not always effectively used and staff did not follow policies and best practice.
- Staff in the diagnostic department did not always manage medicines well. Storage and administration of medicines was not in line with guidance.
- The hospital was developing a system for monitoring patients that did not attend their appointment, however this was not in place at the time of inspection.
- The hospitals management team acknowledged further development was required to support patients with dementia.
- Governance systems in diagnostic imaging did not ensure policies, procedures and guidance was up to date, ratified and reviewed regularly.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Our rating of this location stayed the same. We rated it as good because: • Managers regularly reviewed and adjusted staffing levels and skill mix to keep patients safe from avoidable harm and to provide the right care and treatment. The service used agency staff and bank staff and gave staff a full induction. • Staff had access to training in key skills, staff 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 mainly kept good care records. They mainly managed medicines well. The service managed safety incidents well and learned lessons from them. • Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week. • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. • The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the

Summary of findings

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:

- Compliance with mandatory training was low in some areas due to a pause in training due to Covid 19.
- Some policies and procedures were generic in nature and did not reflect local practices.

Medical care (Including older people's care)

Good

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

- The services we visited were visibly clean and there were good infection prevention and control practices in place.
- The services had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, provided advice to 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,

Summary of findings

took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

- The services 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 endoscopy service had started working towards achieving the Joint Advisory Guidance (JAG) accreditation in 2016. The same issues prevented them from meeting the required criteria, namely the carpeted flooring.

Services for children & young people

Good

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

- The service had enough staff to care for children and young people and keep them safe. Staff had training in key skills, understood how to protect children and young people from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to children and young people, acted on them and kept good care records. They managed medicines well. The service managed incidents well and learned lessons from them.
- Staff provided good care and treatment, gave children and young people enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the

Summary of findings

effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of children and young people, advised them and their families on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

- The service had a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and compassionate. Staff treated children and young people with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided outstanding emotional support to children and young people, families and carers.
- The service had an excellent understanding of children and young people's social and cultural diversity, values and beliefs that may influence their decisions on how they want to receive care, treatment and support. Staff knew how to meet these preferences and were innovative in suggesting additional ideas to meet those needs. Staff actively encouraged children and young people to give their views and raise concerns or complaints. The services saw concerns and complaints as part of driving improvement. Children and young people could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well and staff felt respected, supported and valued. They were focused on the needs of children and young people receiving care. Staff were clear about their roles and accountabilities. The service engaged well with children, young people and the community to plan and manage services and all staff were committed to improving services.

However:

- Some flooring in clinical areas were carpeted which did not follow best practice.

Summary of findings

- The vision and strategy for the department was not fully embedded with staff.
- We found some out of date medical consumables not identified using the services checking system.
- There was no method for monitoring children and young people's appointment attendance, although a system was being developed.

Diagnostic imaging

Requires Improvement

Our rating of this service went down. We rated it as requires improvement because:

- There were shortfalls in mandatory training for staff. Staff mandatory training compliance was 62%, this was below the service target of 95%
- The service did not always control infection risk well.
- Not all staff had received training on how to protect people from abuse in line with national guidance.
- Staff did not always understand how to protect patients from abuse.
- The service did not always manage safety incidents well or learn lessons from them.
- They did not always manage medicines well.
- The service did not take account of all patients' individual needs and there were limited support services for patients with a learning disability or for those living with dementia.
- Staff did used policies and procedures that were not the most recent versions and there were limited measures in place to update these in line with review dates.

However:

- The service had enough staff to care for patients and keep them safe. Staff assessed risks to patients, acted on them and kept good care records.
- Staff provided good care and treatment, gave patients enough to drink.
- Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, and had access to good information. Key services were available to suit patients' needs.
- Staff treated patients with compassion and kindness, respected their privacy and dignity,

Summary of findings

took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

- The service planned care to meet the needs of the communities it served, 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 procedures.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

Outpatients

Good

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

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

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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 provider should ensure resuscitation equipment needs are reviewed for the department. (Regulation 12).
- The provider should ensure monitoring processes for patients who did not attend their appointment are reviewed. (Regulation 12)
- The department should review risks associated with carpets in the consultation rooms.
- The department should review the layout of the department meeting minutes so that incidents are clearly identified and discussed with the team.
- The department should consider the arrangements for recording meetings with their cardiology outpatients' team.
- The department should consider improvements in mandatory training be built upon to reach the provider's minimum targets for all modules.

Summary of findings

Contents

Summary of this inspection

Background to Nuffield Health The Manor Hospital Oxford

Nuffield Health The Manor Hospital Oxford is operated by Nuffield Health Group. Hospital facilities include 25 consulting rooms, six surgical theatres, 68 private en-suite bedrooms, two minor procedure suites and a radiology unit including: mammography, ultrasound, MRI & CT scans. There was also a seven bedded adult critical care unit, a physiotherapy department and two intervention suites for radiology and cardiology. The children and young people's inpatient service had six single en-suite rooms in one dedicated area and saw patients over the age of three. Children and young people were also treated in outpatients from birth. The endoscopy unit consisted of treatment suites, one patient bay, a scope washer and drying room, a patient recovery area, and staff offices. The oncology unit had a patient bay with space for seven patients, two side rooms with en-suite facilities and a quiet room run by a charity.

The hospital provides surgery, medical care, critical care, services for children and young people, outpatients and diagnostic imaging. The hospital is currently registered for the regulated activities surgical procedures, diagnostic and screening procedures, and treatment of disease, disorder or injury.

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

How we carried out this inspection

We carried out this unannounced inspection using our comprehensive inspection methodology on 22 and 23 March 2022. We reviewed policies and procedures, audits, staff training records, risk registers and reports external to the hospital. We did not inspect critical care services during this inspection.

Surgery

During the inspection we spoke with 25 staff including ward and theatre staff, housekeeping staff, hostess staff, pharmacy and physiotherapy staff. We also spoke with four patients and reviewed ten sets of patient records.

Medical Care

During the inspection we visited the endoscopy unit and oncology service. We spoke with two patients. We spoke with 13 members of staff including senior and junior nurses and charity staff. We looked at three sets of patient records.

Services for Children and Young People

During the inspection we visited the outpatient and inpatient departments. We spoke with 15 members of staff including; service leads, anaesthetists, consultants, nurses and play specialists. As well as the children and young people and families on site on the day of inspection. We looked at 10 sets of patients records.

Diagnostic Imaging

During the inspection we visited the radiology unit including: mammography, ultrasound, MRI & CT scan rooms. We spoke with three patients, one family member and ten members of staff. We looked at 10 sets of patient records.

Summary of this inspection

Outpatients

During the inspection we visited all areas of the outpatient department, including gynaecology, dermatology, ear, nose and throat (ENT) and eye clinics, the minor procedures room and the cardiology unit that was located in a separate section of the hospital. We spoke with 10 patients.

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

Outstanding practice

Services for Children and Young People

Staff were in the process of receiving LGTBQIA2S+ paediatric safeguarding training that would provide understanding of specific safeguarding concerns experienced by this group and how staff and outside agencies could support children and young people presenting with these. The paediatric lead nurse had already completed this training and was developing a gender diversity communication and training folder to ensure staff used up to date terminology and language.

The service had a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and compassionate. Staff treated children and young people with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided outstanding emotional support to children and young people, families and carers.

Areas for improvement

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

Surgery

Action the service SHOULD take to improve:

- The service should ensure that staff complete mandatory training including ALS and ILS training (Regulation 12).
- The service should ensure monitoring of quantities for all emergency drugs kept in resuscitation trolleys, according to the internal medicines management and storage policy (Regulation 12).
- The service should consider training recovery staff in Advanced Life Support

Medical Care

Action the service SHOULD take to improve:

- The service should ensure all carpets are removed. Regulation 15 (1)
- The service should consider using a local provider for chemotherapy medication.

Children and Young People's Services

Action the service SHOULD take to improve:

- The service should ensure all carpets are removed. Regulation 15 (1)

Summary of this inspection

- The service should ensure it develops a system for monitoring hospital non-attendance. Regulation 12 (1)
- The service should consider embedding the vision and strategy for the department and hospital with staff.
- The service should consider revising consumable stock checking systems.

Diagnostic Imaging

Action the service MUST take to improve:

- The service must ensure that the correct personal protective equipment is used when undertaking aseptic procedures and the clinical area used for venepuncture is maintained in line with infection control policy. Regulation 12 (1)
- The service must ensure the governance and quality assurance for the department is effective; including for all clinical procedures, servicing of equipment, learning from incidents and the use of current policies and procedures. Regulation 17 (1)
- The service must ensure room and fridge temperatures where medicines are stored are monitored and unused product is disposed of to ensure medicines remain effective. Regulation 12 (1)
- The service must ensure that medicines are prepared and used in a way that ensures consistency, and appropriate staff competency in this area is recorded. Regulation 12 (1)
- The service must ensure that when medicines are supplied in a language other than English, staff have access to instructions in English. Regulation 12 (1)
- The service must ensure that patients are provided with the appropriate medicines information's leaflets when medicines are consumed Regulation 12 (1)
- The service must ensure that staff complete mandatory training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Regulation 12 (1)

Action the service SHOULD take to improve:

- The service should ensure it has measures in place to meet accessibility needs of patients with learning disabilities and those living with dementia. Regulation 9 (1)
- The service should ensure that staff are supported through appraisal or alternative agreements and achieve compliance in all mandatory training. Such as Basic life support, and Radiation Protection. Regulation 12 (1)
- The service should ensure that staff competency training for safeguarding is compliant with the Safeguarding Children and Young People: Roles and competencies for Healthcare Staff, Fourth Edition 2019 Intercollegiate Document, to ensure children and young people are protected from abuse. The training must be delivered at the level according to the job role. Regulation 13 (2).
- The service should consider measures to expedite imaging equipment replacement, so patients are not adversely affected by machine failure.
- The service should consider implementing root cause analysis for radiation incidents in line with recommendations from Radiation Protection Advisor reports.
- The service should consider the patient and service benefits of participating in national clinical trials and clinical audit.
- The service should consider how they advise patients of the ability to have a chaperone at their appointment should they require one.
- The service should consider implementing department level feedback to monitor patient feedback.

Outpatients

Action the service SHOULD take to improve:

- The provider should ensure resuscitation equipment needs are reviewed for the department. (Regulation 12).
- The provider should review monitoring processes for patients who did not attend their appointment. (Regulation 12)

Summary of this inspection

- The department should review risks associated with carpets in the consultation rooms.
- The department should review the layout of the department meeting minutes so that incidents are clearly identified and discussed with the team.
- The department should consider the arrangements for recording meetings with their cardiology outpatients' team.
- The department should consider improvements in mandatory training be built upon to reach the provider's minimum targets for all modules.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Medical care (Including older people's care)	Good	Good	Good	Good	Good	Good
Services for children & young people	Good	Good	☆ Outstanding	Good	Good	Good
Diagnostic imaging	Requires Improvement	Inspected but not rated	Good	Good	Requires Improvement	Requires Improvement
Outpatients	Good	Inspected but not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Surgery

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

Are Surgery safe?

Good

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

Mandatory training

The service provided mandatory training in key skills to most staff, however due to the impact of COVID-19 some modules, especially those requiring face to face contact had not been completed by all staff. Leaders were working towards compliance and had an action plan in place.

Ward and theatre staff received mandatory training, however due to the impact of COVID-19 not all staff were up to date with all modules. The hospital had a programme of mandatory training and monitored compliance. Face to face training had been paused due to the COVID-19 pandemic. Training figures demonstrated compliance, for most subjects were above the hospital's overall target rate of 90%, reaching 96%. In the operating department, only 52% of staff were up to date with their immediate life support training (ILS). However, the service had started one to one training sessions to improve compliance with training targets until they were able to restart group sessions.

Mandatory training and increasing compliance was a key focus for 2022. An action plan had been developed and would be monitored through heads of departments one to one meetings.

The mandatory training was comprehensive and met the needs of patients and staff. Staff used software for eLearning courses. Mandatory training was also was tailored to the staff role.

Managers monitored mandatory training and alerted staff when they needed to update their training. There were processes in place when staff were not up to date with their training. This included a daily email to staff and their manager. Leaders reminded staff to complete mandatory training during staff meetings. The matron and the training coordinator also monitored compliance. Leaders told us staff nonattendance at training was reported to the senior management team.

Safeguarding

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

Good

Surgery

Staff received training specific for their role on how to recognise and report abuse. At the time of the inspection, compliance with safeguarding adults and children levels one and two for both ward and theatre staff was at 100%, above the hospital target of 85%. The Nuffield safeguarding training matrix stated all registered nurses required level three safeguarding adults training. In line with the 'Adult Safeguarding: Roles and Competencies for Health Care Staff, intercollegiate document (August 2018). There was a plan in place to for all registered nurses to be trained to level three within two years.

Staff knew who to inform if they had concerns. All staff including senior staff told us they would raise any safeguarding concerns with their manager, or the safeguarding lead. Leaders told us safeguarding concerns were reported to the safeguarding lead (matron) and the matron would allocate a deputy in their absence. We reviewed two hospital safeguarding incidents and found that they had been handled according to national guidelines and internal policies.

There was a joint safeguarding adults and children policy in place, this was version controlled, in date and due for review in 2024. However, as the policy was central for all Nuffield hospitals it did not contain the details of the local authority or the name of the hospitals safeguarding lead. Staff we spoke with knew how to get help from line management in relation to safeguarding, but not all staff knew who the safeguarding lead was.

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 clean and had suitable furnishings which were clean and well-maintained. The hospital employed a team of housekeeping staff who were highly visible on the day of the inspection. Housekeeping staff kept records of when they completed specific cleaning tasks such as completing deep cleans and preparing patients rooms for admission. The hospital was visibly clean.

Staff took measures to protect patients, visitors and staff from COVID-19. These included patient screening, blue and green patient areas and a one-way flow through the hospital. Leaders encouraged staff to take two lateral flow tests a week.

Staff completed a COVID-19 risk assessment tool for each patient and placed this in the patients notes. Information such as if the patient had been vaccinated, if they had a previous diagnosis of COVID-19 and if they had any symptoms was included in the tool.

Staff used records to identify how well the service prevented infections. Staff screened patients for MRSA prior to hospital admission, this was clearly recorded in the patients notes. We also saw risk assessments for Carbapenemase Producing Enterobacteriaceae (CPE).

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff wore PPE such as face masks, gloves and aprons and disposed of them appropriately. The hospital standard precautions policy required staff to wear eye protection during aerosol generating procedures (AGP), eye protection was available for all staff to use at any time. Staff washed their hands and used hand gel following patient contact; hand gel was readily available to patients and staff.

Good

Surgery

Leaders assessed compliance with hand hygiene using the five moments of hand hygiene approach. We reviewed the infection prevention control (IPC) audits and noted the compliance rate for surgical scrub was 100% in March 2022 and 100% in August 2021. Similarly, hand hygiene audits were scheduled quarterly, and the last two we reviewed had a compliance rate of 97.9% for February 2022, and 96.5 for October 2021.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff used I am clean stickers to show when staff had cleaned items and they were ready for use. In theatres there was a dedicated clean area for returned processed equipment and a dirty area for used equipment

Theatre staff ensured all instruments were decontaminated in line with national guidance. An external company processed all instruments, staff felt this worked well.

Staff worked effectively to prevent, identify and treat surgical site infections. The hospital had recorded four surgical site infections within the last year. Leaders individually checked surgical infection reports every Monday and root cause analysis (RCA's) were completed as required. We reviewed the minutes from an infection prevention meeting dated September 2021 and minutes of ward and theatre meetings from the previous three months and found leaders had discussed infections. Infection prevention control policies were in place. The hospital submitted quarterly data on surgical site infections relating to hips and knees to Public Health England (PHE) via an online reporting system.

The infection prevention and control (IPC) Lead role had been vacant since August 2021. Leaders told us there was a newly appointed IPC Lead due to start on 1 April 2022. In the interim there had been an IPC Committee held in September 2021 chaired by the Ward Manager and the Ward Manager had also held weekly meetings with the National Quality Lead for Infection Prevention. The hospital was an active participant in Infection Prevention Awareness Week.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. Two out of three patients we spoke with felt staff answered their call bells quickly.

The service had suitable facilities to meet the needs of patients' families. The hospital facilities and surgical equipment was readily available and fit for purpose. The hospital had six operating theatres.

The hospital had an on-site estates team who staff felt provided a good response. Quarterly meetings were held with estates to discuss any maintenance requirements. The surgical ward was on a separate floor from the theatres with lift access. All rooms were en-suite with a toilet and walk in shower facilities. Rooms had storage facilities with key code access for patients to store belongings safely.

The service had enough suitable equipment to help them to safely care for patients.

The hospital used an external company in relation to medical devices. The company held the asset register and attended the hospital to service equipment. If there was an urgent requirement there was a hotline staff could telephone and the company would attend the same day or within 24 hours. An external company tested electrical equipment for safety; the company had serviced the equipment within the recommended timescale.

Staff checked resuscitation trolleys weekly and used tamperproof tags. We reviewed the equipment checklists for the previous three months and found no gaps. We also reviewed the contents of three resuscitation trolleys from theatres and wards and found they were tidy, visibly clean, and that the consumables were within date.

Staff disposed of clinical waste safely. Staff disposed of clinical waste appropriately using coloured clinical waste bags. An external company collected any waste; staff ensured they did not overfill sharps containers and they had dated them.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff had processes in place to identify and quickly act upon patients at risk of deterioration

Staff used a nationally recognised tool to identify deteriorating patients and knew how to escalate them appropriately. Staff completed patient observations and used a National Early Warning Score (NEWS2) to detect and respond to patient deterioration. Staff kept discharge criteria and escalation protocols with the chart. Staff we spoke with understood the discharge and escalation criteria. Leaders completed audits around NEWS2 documentation (January and February 2022) and found good compliance in most areas.

Staff understood the risks around sepsis and told us they could access sepsis training online. Staff were aware of the sepsis six and the sepsis checklist. Staff kept a sepsis box in the clinical room. The box had a sepsis screening and action tool and other items staff may need if sepsis was a concern and was checked daily. There was a standard operating procedure available on the intranet for the initial management of sepsis.

Staff working with cancer patients and involved in giving advice used the UK Oncology Nurses Society (UKONS) triage tool. The society developed the tool for staff who provided the 24-hour advice lines for patients receiving specific therapies and treatment.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly. Staff completed a pre-operative assessment for patients undergoing a surgical procedure. This helped staff identify risks to the patient, leaders told us they only accepted patients if they felt they could do so safely. Staff completed patient risk assessments on admission to the hospital. Patient notes included risk assessments around COVID-19, Venous thromboembolism (VTE), malnutrition, skin integrity, nutrition and falls. The hospital followed the American Society of Anesthesiologists (ASA) classification and Routine preoperative tests for elective surgery NICE guideline [NG45]. ASA grades are a simple scale describing a person's fitness to be given an anaesthetic for a procedure.

Arrangements were in place for the provision blood products should a transfusion be required and staff were trained to use the system .

Staff knew about and dealt with any specific risk issues We observed a daily team brief and debrief in theatre and found all staff engaged. In the debrief leaders discussed theatre lists on the day, any issues that needed addressing and the meeting was attended by all theatre staff. Both the team brief and the debrief were well documented.

Staff completed the World Health Organisation (WHO) surgical checklist for each patient undergoing a surgical procedure. The safety checklists are designed to identify a potential error before it results in harm. We reviewed ten copies of the checklist and found staff had completed them appropriately.

Good

Surgery

Leaders completed a patient risk assessment audit. Ward departmental meeting minutes dated September 2021 noted areas for improvement as recording of skin inspection on admission or daily. Actions included ensuring staff provided patients with an explanation around risk assessments and that staff completed them daily.

The hospital followed an agreement to ensure transfer of any patients in need of critical care. The document set out the guidelines for the transfer of patients who become critically ill and required a transfer to the local NHS trust.

The service provided 24-hour support to patients following their discharge. Staff gave patients a discharge pack which had the contact details of the outpatient's department, the ward and the pharmacy. The pack also provided patients with information on wound care, getting up and about after surgery, pain relief and complications; risks post-surgery were included such as blood clots, infection and chest pain, it also covered pressure ulcers.

Each morning a daily huddle took place within theatres were any staffing gaps were highlighted. Leaders told us there had not been any recent incidents where suitable skill mix was not available. No recovery staff were trained in Advanced Life Support (ALS). The RCoA (The Royal College of Anaesthetists) guidance is that staff in recovery should have access to an ALS provider or anaesthetist and according to the training records, no staff in theatres or on the wards had ALS training. However, the resident medical officer was trained in advanced life support and available on site 24 hours a day, which reduced the risk to patient safety.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. The number of nurses and healthcare assistants for most shifts we reviewed matched the planned numbers. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

Senior staff adjusted staffing levels daily according to the needs of patients. Cover was provided for staff absence and managers requested bank and agency staff who were familiar with the service. They made sure all bank and agency staff had a full induction and understood the service.

At the time of the inspection there were four vacancies, for a scrub nurse, a scrub bank theatre practitioner, a substantive theatre practitioner and a bank theatre practitioner. The theatre staffing standard operating procedure (SOP) set out the agreed staffing levels for theatre lists. This reflected recommendations by the Association for Perioperative Practice (AFPP) and clearly stated a procedure could only begin with the agreed number of staff and skill mix. We observed three surgical procedures on the day of the inspection and four anaesthetics and noted theatre staffing was within recommended guidelines. Leaders told us how some theatre staff were multi skilled; this meant they could step into different roles if required. Leaders told us they would cancel surgical procedures or reduce them if staffing levels were not safe.

There was always a member of the senior leadership team on call as well as a theatre on call rota with staff on call from 9pm until 8am each day.

The ward manager could adjust staffing levels daily according to the needs of patients. Leaders in theatre held a daily capacity meeting to discuss the next three weeks theatre lists. This ensured leaders considered staffing requirements and skill mix ahead of time. The hospital had its own bank staff alongside the use of a regular agency.

Good

Surgery

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

Medical staffing

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

The service had enough medical staff to keep patients safe.Consultants at the hospital worked on a practicing privilege basis so were not employed at the hospital. Through their contractual arrangements, consultants were required to be present on site until a procedure was concluded and to be available on call for the duration of a patient's hospital stay. If they were not going to be available, it was their responsibility to arrange cover. Further, leaders told us how they managed any gaps in cover and used alternative specialities if the planned consultant was not available to see the patients.

The hospital contracted two registered medical officers (RMO's) through an external company. The RMO's covered 24 hours a day 365 days a year. There had not been any gaps in provision and the two current RMO's had been with the hospital several months to ensure consistency.

Anaesthetists were governed by practicing privileges which were undergoing review. There had not been any incidents recorded of an anaesthetist being unavailable.

Records

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

Patient notes were comprehensive, and all staff could access them easily. All patient care notes were in paper format and kept in locked drawers. Leaders told us there was a plan to move to electronic patient notes from April 2022.

We reviewed ten patient records and found them to include the information needed to deliver safe care and treatment. They were available to relevant staff in a timely and accessible way. Patient notes included imaging results, care and risk assessments and case notes.

Audits of care record surgical inpatients for January 2022 showed a compliance rate of 95.2%. Staff were advised of areas were improvements were required. These had included ensuring they took the patients temperature within the last hour when taking them to theatre and ensuring staff signed recovery handovers when patients returned to the ward.

Patient notes we reviewed were comprehensive and all staff could access them easily. They were stored securely. When patients transferred to a new team, there were no delays in staff accessing their records. All the notes we reviewed contained detailed information, and evidence of multidisciplinary work. We observed staff being able to obtain patient notes when needed, to ensure continuity of care.

Medicines

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

The service had a comprehensive medicines management policy, which covered obtaining, prescribing, recording, handling, storage, security, administration and disposal of medicines. Staff completed medicines records accurately and kept them up-to-date Medicine records were completed appropriately – including allergies and VTE assessments.

Good

Surgery

The hospital had its own pharmacy with their staff being responsible for the supply and top-up of medicines used in the theatre area and inpatient wards and take-home medicines for patients. However, on the day of the inspection we found that the check forms for contents of the resuscitation trolleys did not match the internal medicines management and storage policy. Staff were not monitoring and updating the quantities of diazepam kept in the resuscitation trolleys in line with the internal policy and national guidelines. There was a risk the diazepam could be removed without staff being aware. We raised this with the pharmacy and ward managers who gave assurance the checklists would be updated to ensure this was accurately monitored.

A pharmacist was on site between 9am and 5pm Monday to Friday and between 9.30am and midday on Saturday. A pharmacist was on call 24 hours a day, seven days a week to provide an out of hours service when required to support staff. The on-call pharmacist was contacted for any controlled drugs (CD) if this was required out of hours.

Staff stored and managed all medicines safely. Medicines were stored in locked cupboards on the wards and in the theatre area. We checked a selection of medicines and found all were in date and kept in line with manufacturers advice. Stock matched the records. Fridge temperatures were recorded daily, and staff sought advice from the pharmacy team when the temperatures were found to be outside recommended ranges.

CDs were stored securely and the CD register reflected any CD administered had two signatures recorded as required. Stock matched the register. Staff carried out daily checks of their CD stock and records were clearly maintained. Staff were clear and knowledgeable about the managements of CDs. We observed staff dispensing and administering a CD for one patient. They ensured the CD register was signed only after this had been administered which was in line with best practice.

Medicines prescribed on the medicine chart were dated and signed by the prescriber. Prescriptions detailed the dose and the time the medicine needed to be administered. Nurses signed to demonstrate they had administered the medicine to the patient. Staff reviewed patients' medicines regularly and provided specific advice to patients about their medicines. The resident medical officer (RMO) sought advice from the consultant surgeon or anaesthetist prior to changing any patient's medicine as the consultant had overall responsibility for the patients' care.

Medicines that needed to be kept below a certain temperature were stored in locked fridges. Ambient and fridge temperatures were checked daily and stored within the correct temperature range. Staff knew what to do if temperatures were out of range. All medicines checked were in date.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents. 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. Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses; all incidents were recorded on an electronic recording system. Incidents were reviewed daily, root cause analysis (RCA's) were then completed if relevant. The matron reviewed RCA's before they were closed. The service had not had any recent never events within the surgical core service in the past 12 months. We reviewed three surgical incidents and found the reviews and shared learning to be in line with internal policies and national guidance.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff understood the principles of duty of candour and the importance of being open and

Good

Surgery

honest. The duty of candour is a regulatory duty that relates to openness and transparency and requires the providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support for that person. The hospital had an open and duty of candour policy in place. The hospital manager apologised to patients when care and treatment fell below the expected standards and provided an explanation of events.

Staff received feedback from investigation of incidents. We reviewed six sets of ward and theatre departmental meeting minutes from the previous 12 months and saw incidents were on the agenda. Leaders discussed incidents in daily (whole hospital) huddles to ensure they shared any learning.

Staff recorded all incidents via an electronic system. Falls, venous thromboembolism (VTE's) and pressure ulcers were always reviewed as a root cause analysis (RCA). The RCA was then reviewed and approved locally at the hospital governance committee with any actions recorded as an action from the meeting.

Are Surgery effective?

Good

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The hospital had policies and procedures in place to ensure care and treatment was in line with national guidance. Policies referenced national guidance including the National Institute for Health and Care Excellence (NICE), The Royal College of Surgeons' Standards for consultant led surgical care and the recommendations from the Association of Anaesthetists of Great Britain and Ireland (AAGBI). Staff were able to access policies on the intranet and knew where to find them. Leaders ensured care was provided in line with national guidance and standards by completing various audits. Leaders discussed audits in quarterly quality and safety meetings.

We reviewed six sets of meeting minutes from the ward meetings in the previous 12 months and saw staff discussed the resuscitation council guidelines and algorithms.

The hospital had a policy for the recognition and initial management of sepsis. The policy signposted clinical staff to the most recent guidance in the recognition and management of sepsis and included information on the sepsis six. Staff told us they were able to access online training in relation to sepsis.

Nutrition and hydration

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

Good

Surgery

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Patients meals were prepared on site; this meant kitchen staff could cater for any special diets or religious requirements. The hospital had specific staff who acted as hosts and gathered information from patients around dietary or religious needs. There was a notice board in the kitchen area which detailed any special requirements, in addition to laminated menu cards. Patient comments on the food included it was “very good” and there was a “nice” choice of food.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Patient notes contained information on the patients nutritional score which staff assessed using a nationally recognised tool. Nursing staff could tell us the steps they would take if patients were suffering from nausea and vomiting.

Staff made referrals for specialist dietary support. The hospital did not have its own dietitian, however, staff made appropriate referrals if needed. Staff gave us examples of making such referrals, and we also saw them in some of the patient notes we reviewed.

Patients waiting to have surgery were not left nil by mouth for long periods. Staff sent patients a letter to advise of any fasting requirements for surgery. We reviewed a letter sent to a patient and found recommended fasting was within fasting guidelines; fasting details were recorded in patients notes.

Pain relief

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

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff worked within the National Institute for Health and Care Excellence (NICE) guidance for pain management.

The hospital had three staff (physiotherapist, pharmacy staff member and a nurse) who had completed a course in pain management. Staff could also seek advice on pain management from two anaesthetists who ran pain management clinics.

The ward had a communication picture and photo toolkit in place which included a communication tool around pain. Staff recorded pain scores in patient notes using a recognised tool.

Patients received pain relief soon after requesting it. Patients felt their pain was well controlled. Pharmacy staff telephoned patients pre-operatively to talk about pain management.

Staff prescribed, administered and recorded pain relief accurately. Staff prescribed and recorded any medicines in medicine administration charts. The review of records relating to pain management was included in the notes' audits. We reviewed the ward departmental meeting minutes from September 2021 and noted the pain audit score was 89%. Staff were reminded to follow up pain scores and pain relief given with documentation, including if the pain relief given was effective or if patients had refused.

Patient outcomes

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

Good

Surgery

Managers used information from the audits to improve care and treatment. Audits to monitor how staff cared for people and to identify any learning needs were completed. Staff completed audits around pain relief, infection prevention control, NEWS2, the environment and consent. Staff meeting minutes demonstrated key learning from audit results. The hospital used a dedicated tool to audit and record information related to surgical site infections.

The service participated in relevant national clinical audits. The hospital collected surgical Patient Reported Outcome Measures (PROM's) data. PROM's are condition specific questionnaires that measure the severity of the condition from the perspective of the patient. For NHS funded patients, PROMs were mandated for patients undergoing either hip or knee replacement surgery (primary and revisions). For privately funded patients, PROMs were mandated for 13 surgical procedures by the Competition and Markets Authority. For Hip replacement surgery 98.4% of patients reported an improvement and for knee replacement surgery this was 94% , both of which are comparable with national figures

Staff documented all implants in patients notes and completed the National Joint Registry (NJR) form. The NJR was set up by the Department of Health and Welsh Government to collect information in England and Wales on joint replacement operations and to monitor the performance of implants, hospitals and surgeons. Staff uploaded details of joint replacements onto the system, they had time out of their usual duties to do this. One of the staff were also a point of contact for the NJR.

Managers and staff used the results to improve patients' outcomes. Senior staff told us how an internal theatre review had taken place and the quality manager had not raised any concerns. Theatre utilisation was benchmarked against other hospitals and discussed in monthly reviews.

Managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits. Audit updates were a regular item on the ward meeting agenda and displayed on the ward.

The service monitored the patient's length of stay. From data available up to September 2021 for the inpatient procedures with the top 10 longest length of stay, the service was similar with the private inpatient mean and the NHS inpatient mean. The service also monitored the number and reason for cancelled operations, unplanned returns to theatre, unplanned readmissions, unplanned transfers out and conversions to overnight stays. Information provided demonstrated this information was reviewed and monitored for any trends and impact on outcomes. The information was discussed at both the medical advisory committee and the governance committees.

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 completed a variety of mandatory and role specific training. Competencies were required for each role and included sepsis, transfer and VTE. Competencies were recorded in a file for each member of staff.

Staff completed competency documents relating to their role. These included different anaesthesia techniques such as local anaesthetic, general anaesthetic and sedation, equipment competencies and orientation to the environment. Preceptors were allocated to each new staff member.

The role of the Medical Advisory committee (MAC) included supporting the hospital senior managers to ensure that all consultants were skilled, competent and experienced to perform the treatments undertaken. Practising privileges were

granted for consultants to carry out specified procedures using a scope of practice document, these were reviewed annually. Registration with the General Medical Council (GMC), the consultants' registration on the relevant specialist register, disclosure barring service (DBS) check and indemnity insurance were all checked by the hospital and ratified by the MAC. An email was automatically generated to remind a consultant if for example their appraisal or indemnity was overdue or expired.

Managers gave all new staff a full induction tailored to their role before they started work. Managers supported staff to develop through yearly, constructive appraisals of their work. At the time of our inspection, 60% of the ward staff had received their appraisals. This was below the hospital target set to 80%. However, the remaining appraisals were reported to have been scheduled . In theatres, the appraisals were scheduled for April 2022. Staff told us they found the appraisal helped with progression and they were encouraged to pursue interests such as leading in particular areas. Managers made sure staff attended team meetings or had access to full notes when they could not attend. Ward meetings were held monthly and minuted.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us they had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The registered manager reviewed records of consultant surgeon and anaesthetist appraisals (including consultants completing cosmetic surgery). This process covered continuing professional development, clinical competencies and training requirements.

Surgeons were part of the Private Healthcare Information Network (PHIN) network, details were uploaded of any complaints and infections. The organisation provides unbiased information on all private hospitals and consultants for everyone in the UK to access.

The hospital offered new staff a comprehensive induction programme. All new staff had up to six weeks where they would spend time in different areas of the hospital. This provided new staff with an understanding of how each area of the hospital worked, how the business worked and to get to know the site. Staff told us there were good opportunities for education.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. All necessary staff including those in different teams and departments were involved in assessing, planning and delivering care and treatment. Each morning the matron held a daily whole hospital safety huddle. The huddle was well attended and included representatives from each hospital department. The agenda included the opportunity discuss any patient related issues and other areas of risk such as staffing and supplies.

During our inspection we observed effective multidisciplinary working between different teams while carrying out patient care. We saw all staff including physiotherapy and pharmacy staff and ward and theatre staff working well together.

Seven-day services

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

Good

Surgery

Consultants led daily ward rounds on all wards. Consultants reviewed patients depending on their care pathway. Consultants visited patients in their rooms following surgical procedures and daily thereafter.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Surgical procedures took place on weekdays only between 8.30 am and 8pm, theatre staff worked until 9pm. There was a theatre on call rota in place which noted the staff on call from 9pm until 8am each day.

There were two registered medical officers (RMO's) who rotated on the hospital site 24 hours a day seven days a week, 365 days a year. This meant staff could access medical advice when they needed it throughout the day and night.

Physiotherapy services were available seven days a week with a reduced service at the weekend. Physio working hours were flexible and dependent on surgical lists. This meant they could accommodate later theatre lists and see all the patients on the day. Diagnostic services ran from Monday to Friday with essential staff available on a Saturday and an on-call system on a Sunday.

Health promotion

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

Staff at the service would signpost patients to relevant services to promote a healthy lifestyle. Staff signposted patients to other services if needed but told us they gave patients advice in the pre op stage of their journey. The service had relevant information promoting healthy lifestyles and support on wards and units. Staff assessed each patient's health prior to being admitted and provided support for any individual needs to live a healthier lifestyle. Each patient had an in-depth health assessment as part of their pre assessment, the assessment including key health questions and the patients' health status.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff told us the majority of admitted patients had the capacity to make their own decisions. Patients who lacked capacity were identified during the pre-operative assessment process. If a best interest decision had to be made, this would be with the consultant, but these were rare.

Staff made sure patients consented to treatment based on all the information available. Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patient records we reviewed showed consent was obtained in accordance with hospital policy.

Staff could describe and knew how to access the policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. There was an up-to-date consent policy for staff to follow. They told us they would go to the matron for advice.

Good

Surgery

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The hospital provided staff with mandatory training around the Mental Capacity Act 2005 and Deprivation of Liberty and met the hospitals compliance rate of 100%.

Are Surgery caring?

Good

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

Compassionate care

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

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff recognised patients' individual needs such as the need to pray or to eat a specific diet. We saw information leaflets were available around Jehovah's witnesses and the refusal of blood products. The hospital had a privacy and dignity policy in place.

Patients said staff treated them well and with kindness. Most patients we spoke with told us staff treated them with respect, introduced themselves, knocked on their doors before they entered and their privacy and dignity were respected. However, one patient we spoke with told us about a poor experience of care in terms of privacy and dignity. The hospital monitored patient outcome surveys. We reviewed a survey from February 2022, which showed that 67% were likely to recommend the hospital to friends and family if they needed similar care or treatment. This was an improving picture. Patient forums had not continued during the pandemic, but leaders told us they would resume in May 2022.

We reviewed a selection of twenty thank you cards, comments included "Thank you so much for always thinking of us all, and for all the generosity you have shown us in the past several months", "The patient care was absolutely second to none. Totally brilliant."

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff made up pre- and post-operative packs for oncology patients using the service. Staff told us they would also print of information from the Macmillan service if required. We noted the Nuffield Heath internet site had advice hubs where patients could find information on a variety of subjects including lifestyle management and emotional wellbeing.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff gave an example of when a patient had been distressed and the steps, they had taken to support the patient. Staff told us they helped to reassure patients by keeping them informed, up to date and discussing any expectations.

Good

Surgery

Leaders providing cancer services told us staff offered psychologist support to all patients living with cancer, if they needed it; staff completed this via a referral.

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 provided patients with a copy of the paying for yourself: terms & Conditions leaflet. The leaflet covered general terms, cancelation charges and what was included in any treatment. Detailed information on costs were also available on the main Nuffield Health hospital website.

Staff talked with patients, families and carers in a way they could understand. Patients told us staff gave them transparent information prior to admission and they explained any costs.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff gave patients the opportunity to provide feedback on the care and treatment they received. Leaders discussed patient journeys in hospital board meetings as well as patient satisfaction survey results.

Staff provided patients with a going home booklet on discharge. The booklet reminded patients they could contact staff if they had any concerns or if they noticed anything unusual. Patients could contact someone at the hospital 24 hours a day.

Are Surgery responsive?

Good

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

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population. The hospital had supported the local NHS throughout the COVID-19 pandemic. This helped to relieve pressure on local services. The hospital also provided cancer services for patients. Staff told us if a patient had a learning disability, they would welcome their carers to support them throughout their stay. The hospital had a mixture of NHS and private patients and was flexible with operation dates if needed.

Facilities and premises were appropriate for the services being delivered.The hospital had six theatres; appropriate facilities were also in place for post anaesthesia care.

All areas were large enough to accommodate wheelchairs and patients with mobility issues. Patient toilets were disability friendly and the car park has disabled access. All the rooms were en-suite and had walk in shower facilities, they also had long call bells and toilet raisers in some instances. There was a lift available to all floors and the ward areas, theatres and diagnostic services were all within easy reach.

Good

Surgery

Managers monitored and took action to minimise missed appointments. The hospital policy for missed appointments was they would telephone patients who did not attend (DNA) to establish the reason for non-attendance. In the event the patient was not contactable by telephone, the surgeon's secretary would be informed to manage accordingly.

Meeting people's individual needs

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

Staff completed equality and diversity training annually as part of their mandatory training. At the time of our inspection training compliance across staff working in the surgery service was 100%. Staff gave us several examples of supporting patients with protected characteristics under the Equality Act. Staff we spoke with displayed knowledge and understanding of the training on equality and gave examples of how they applied this learning.

The service had an in-date equality and diversity policy which we reviewed and found to be detailed. Surgical patients' individual needs were discussed during booking and pre-admission assessment. Staff used this information to provide safe care and treatment and mitigate any possible risk to the patient. If during pre-admission assessment staff identified the service could not meet the patient's needs, the patient would not receive treatment at the hospital. The hospital referred the patients to an alternative health care provider who could support their needs. The hospital did not have the facilities to support the care of patients with high complex needs. Therefore, this patient group was not admitted to the hospital. However, patients who had a learning disability or dementia could be admitted subject to the outcome of risk assessments.

Patients received information explaining about their surgical procedures and what to expect throughout their hospital visits. This information was designed to address patients' questions about their forthcoming procedures. Information included details on preparing for hospital, what to bring with you and what to expect following their treatment. This information was also available to patients on the hospital's internet webpage.

The hospital had measures to meet the Accessible Information Standard (AIS). Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. At the daily hospital staff meeting patients who met the accessible information standard criteria were discussed to ensure their information and communication support needs were met and they received smooth patient care across the hospital. Information leaflets were also available in large print and could be obtained in braille if required. Hearing loops were available across the site.

Staff working on the surgical ward used coded discs on their patient board to identify patients who needed additional support. Staff told us this was a good visual reminder for them that they might need to use a different communication style when caring for the patient. For example, if a patient had a needle phobia or was hard of hearing. Staff showed us communication aids they used to help interact with their patients if needed.

The service had access to an interpreting service for patients whose first language was not English and signers if needed. We saw posters in different languages which explained services the hospital offered such as verbal translation and interpreter services and how to make a complaint. Staff we spoke with were aware of how to use these services and gave us examples of supporting patients who needed an interpreter. Further, staff were aware of the national guidance to not use family members, friends or staff members who could speak a foreign language, unless in an emergency.

Access and flow

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

Good

Surgery

The hospital followed corporate and local policies and procedures for the management of the patient's journey, from the time of booking the appointment until discharge and after care. Staff we spoke with were aware of these policies and procedures.

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

The hospital had established a clear booking process for appointments and hospital admissions. Patients told us the hospital had a good and efficient booking process.

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. Staff reported cancelations on the incident reporting system. We reviewed two incidents when surgical procedures had been cancelled and saw staff made arrangements to book patient on the next theatre list when it was appropriate to do so.

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff started discharge planning at the pre assessment stage of the patient's journey. Staff asked patients for information on their support network; staff told us they spoke to the patient again on admission. Further, the hospital had a team of physiotherapists on site who were able to give staff and patients advice following surgery. Staff provided patients with a discharge booklet with telephone numbers of who to contact if they had any concerns after discharge.

Managers checked the number of delayed discharges and took action to prevent them. Leaders discussed delayed discharges at quarterly quality and safety meetings. Staff reported delayed discharges as incidents and recorded the reasons for the delay, this meant any learning was identified and shared with the senior management teams.

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.

Staff understood the policy on complaints and knew how to handle them. There was a complaints policy in place. Staff knew what to do if a patient raised a complaint such as speaking to the patient, trying to resolve on a local level and escalating to the ward manager.

Managers investigated complaints and identified themes. We reviewed themes and trends for the 21 surgery complaints from the past six months. The hospital identified communication and discharge arrangements as the main causes and included action to improve in their assessment. There were no complaints referred to the Independent Sector Complaints Adjudication Service in the past 12 months.

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints went into a central system and onto the corporate complaints team and were discussed in quarterly quality and safety meetings; timescales were in place monitored via key performance indicators. We noted leaders discussed complaints in ward departmental meetings. We reviewed several meeting minutes from the previous 12 months and saw leaders shared a complaints tracker. The tracker had details of the complaint and the actions taken as a result and helped to identify any themes and trends.

Are Surgery well-led?

Good

Surgery

Good

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

Leadership

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

There was a clear leadership structure in place. The leadership team included the hospital director, a matron, a theatre manager and a ward sister. Leadership roles were clearly identified in the Nuffield Health the Manor Oxford organisational structure. Staff told us leaders were visible and approachable. There was a vacant position for a sales and services manager. Clinical services reported to the Matron and support services were at the current time being overseen by the hospital director. Staff said leaders were visible and approachable. The Matron held a weekly session where staff could drop in and speak with them.

Leaders encouraged staff to take on senior roles; staff gave examples of being promoted and having the opportunity to apply for senior positions.

Leaders were able to identify the priorities and verbalise the issues they faced. Leaders identified workforce challenges within staff, quality and board meetings. Priorities at the time of the inspection included recruitment and improving compliance around mandatory training which leaders had paused due to COVID-19.

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 hospital director had developed five overarching aims for the hospital. The matron's objectives supported these aims. Guiding principles identified within the provider level strategy including being purpose led, beneficiary first, outcomes driven, sustainable, empowered teams and collaborating with partners. Various strands were also identified such as charitable purpose, strategic intent, guiding principles, strategic aims and organisation enablers. The strategy was an agenda item within the board meetings. Following discussions with department leads, the development of service specific mission statements to support the aims were in their infancy. The hospital had been working closely with the local NHS trust throughout the COVID-19 pandemic and treating NHS patients' therefore supporting the wider health economy.

Culture

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

Staff told us they felt supported, respected and valued by their leaders. Staff commented how the hospital was a lovely place to work, a good environment to work in, how staff worked well as a team and how their opinions were listened to.

There was a strong emphasis on staff wellbeing. Staff had access to the occupational health service. The hospital completed regular pulse surveys to find out how staff were feeling. Leaders thanked staff for taking the time to complete surveys and advised them of the results. Equality and diversity were written into the Nuffield Policies. We saw there was a suggestion box in place at the nurses' station.

We saw good news/success stories were shared in staff meetings. We reviewed several sets of theatre staff meeting minutes from the past 12 months and saw positive feedback was shared and staff were thanked for their continued support and hard work.

Leaders spoke of staff incentives such as raffle tickets to win a monthly prize, we care awards, working with staff around the leadership structure as well as offering financial incentives to new staff (golden handshake). The hospital was actively involved in the Private Healthcare Information Network (PHIN) and encouraged its consultants to do so. At the time of the inspection the hospital was working with the departments to ensure profiles were actioned; details of training days had been sent to relevant staff to accommodate any queries they may have.

Staff submitted relevant data to PHIN monthly, the information sent included inpatient and day case activity, satisfaction questions, outcomes and adverse events. Locally each hospital had access to the PHIN portal to view and encourage consultant engagement with PHIN.

There was not a local freedom to speak up guardian, but one was available at corporate level for staff to access. Staff told us they felt confident to raise concerns and to speak up.

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 an established meeting structure with all sub committees reporting to either the quality and safety committee or the health and safety committee both of which reported to the senior management team. This was confirmed by a review of meeting minutes. Any actions were clearly captured with an identified lead and followed up at the next meeting.

The medical advisory committee (MAC) met every six to eight weeks, there were consultant representatives from each speciality. The MAC chair and hospital director had a weekly structured meeting. The MAC took an active role in the review of applications for practicing privileges and requests for new procedures. Operational matters, and hospital performance were reviewed at this meeting.

Consultants were granted practicing privileges following a structured process, including a recommendation from the MAC or their MAC speciality representative. Practicing privileges were suspended if the required documentation, such as indemnity insurance was not kept current.

There was a hospital board in place who held monthly meetings. The registered manager/chair attended the meetings in addition to the hospital matron and other committee members. Areas covered at board meetings included quality and safety governance, finance, complaints, compliance, partners improvement planning and governance and information security.

The hospital held several meetings for relevant staff to meet, discuss and learn from performance. This included the medical advisory committee (MAC) and quarterly quality and safety meetings.

Good

Surgery

We saw regular ward departmental meetings took place. Leaders discussed areas of governance such as new policies and procedures, audits, costs and revenues.

Robust arrangements were in place for granting and reviewing practicing privileges; this included a monthly compliance report, initial meetings with the consultant when the registered manager formally discusses areas such as governance, complaints, behaviours and the working of the hospital. Consultants received an induction and support from a member of staff. There was a formal review process every two years. As part of the review the registered manager reviewed the consultant's activity, complaints, trends and ensure they understood any policies. A practicing privileges policy was in place. They also told us if a consultant was suspended, they would contact the hospital they worked at and notify them of any suspensions.

However, policies were drafted at a corporate level and did not always reflect the local areas or define some important details. For example, the medicines management policy did not give detail around actual processes needed, such as monitoring and storage of diazepam in the resuscitation trolleys.

Management of risk, issues and performance

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

There were arrangements in place for identifying, recording and managing risks, issues and mitigating actions. Leaders identified risks in staff meeting minutes, quality and safety meetings and in board meetings; there was a whole hospital risk register in place. Leaders also discussed risks in daily departmental or whole hospital huddles and kept departmental risk registers.

The hospital leadership team had good oversight of risks recorded on the hospital risk register. They recognised challenges with the ageing estate, equipment and staffing. Further, following our inspection, the risk register was updated to include the emergency medicines issues. Risks were discussed at leadership meetings, and the quality and safety committee.

The clinical governance lead focused on reviewing incidents, and sharing information and learnings, through the clinical effectiveness and audit committee to department meetings and outcomes with learning reports circulated to all staff. An open weekly learning from incidents forum also took place.

There was a central audit plan and with each department lead having responsibility for the audits for their area. The hospital director monitored consultant performance. There was a central reporting system for collecting performance information and the hospital had access to this information, they were also benchmarked against others in the Nuffield Hospital group. Reports generated by the hospital and the hospital director were presented to the relevant committees for scrutiny and oversight.

Information Management

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

Good

Surgery

The hospital submitted information to external bodies such as the National Joint Register (NJR), The Private Healthcare Information Network (PHIN) and Patient reported Outcome measures (PROMS). The hospital allocated specific staff to input data into the system and ensure a point of contact.

Data was captured electronically; analytic software was used to provide themes and trends. A central review of data was undertaken including analysis by speciality expert advisory groups, analysis and critique by regional quality care partners and the corporate quality lead.

Engagement

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

The hospital director had introduced staff forums. These had been paused during the COVID-19 pandemic, and had recently restarted. Further, staff were invited to participate in a monthly survey, each month there was a different question. This was a new initiative and staff up-take was at 30%.

The service gathered people's views and experiences and acted upon them to shape and improve the services and culture. We saw leaders collated patient experience and compiled them into reports; patient journeys were an agenda item in board meetings.

Further, the service used a diversity dashboard, which included information about staff with protected characteristics and was used to drive recruitment of people from minority backgrounds.

Patient satisfaction surveys looked at many areas of the patient's journey and trends over time. Leaders designed questions to cover different areas of the journey such as from arrival at the hospital, the treatment by the consultant, COVID-19 safety and staff and treatment experience.

The hospital had regular communication with clinical commissioning groups (CCG) and the local NHS trust. The hospital held meetings with third party providers as a way of monitoring any service level agreements. The registered manager attended these meetings and the minutes of the meetings were retained.

Nuffield Health produced and shared quality reports with data on individual hospital performance. The reports included information on medical governance, incidents, patient experience and complaints.

Learning, continuous improvement and innovation

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

Leaders and staff spoke positively about improving services. Quality improvement was embedded in the culture of the service as evident in the meeting minutes reviewed.

We saw examples of quality improvement leaders had implemented throughout the service. As part of quality improvement, the hospital had developed accessible communication folders to further support staff communication with patients and carers with additional needs. Further, staff told us there was a good leadership academy where individualised opportunities existed for everyone.

Good

Medical care (Including older people's care)

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

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

Good

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

Mandatory training

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

Staff received and kept up to date with their mandatory training. The Nuffield Health 'Role Essentials Training Policy' clearly outlined all mandatory training modules and the required frequency per job role. The mandatory training was comprehensive and met the needs of patients and staff.

Training figures demonstrated: oncology staff had completed 100% of their mandatory training while endoscopy and theatre staff had reached 94%, with basic and immediate life support training lower in attendance.

We spoke with senior oncology staff and they told us staff took part in simulation exercises run both in-house and by external companies. For example, what to do in case of cytotoxic spillage or with a patient who suffered a stroke as an inpatient. We saw a report from a resuscitation officer after an unannounced simulation exercise, which outlined staff responses and areas for improvement. The resuscitation officer shared outcomes and learning required at a debrief following the exercise.

Managers monitored mandatory training and alerted staff when they needed to update their training. A notice board in the endoscopy unit displayed which members of staff needed to complete mandatory training modules to become compliant.

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 knew how to make a safeguarding referral and who to inform if they had concerns. Notice boards displayed up to date information about safeguarding. For example, how to identify concerns and who to contact. We saw an example of an incident raised in the endoscopy service, which required referral to Social Services. Staff recorded the action taken, the response of Social Services and the continuing support for the patient.

As part of mandatory training staff received training specific for their role on how to recognise and report abuse. This included both adult and children and young people safeguarding. Compliance with this module was 100% for both oncology and endoscopy staff.

Managers kept folders in staff offices holding a variety of information relating to safeguarding. For example, we saw the Oxfordshire Safeguarding Adults Board (OSAB) "Threshold for Access to Safeguarding Services" document in a folder on the endoscopy unit. Information and documents were up to date. Managers ensured that information in the folders related to both adults and children.

Cleanliness, infection control and hygiene

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

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. Staff kept their units tidy and uncluttered. This included storage areas as well as the wards and waiting rooms.

Staff cleaned equipment after patient contact and labelled equipment to show when they had last cleaned it. 'I am clean' stickers were in use on all equipment checked.

Cleaning records were up to date and signed and showed that all areas were cleaned regularly. Nursing staff told us that the in-house cleaning team responded promptly to any request as required.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff donned and doffed PPE in line with current guidance. Notice boards across the units displayed information on PPE. For example, what type of PPE to use in certain situations. This information was accessible to staff, patients, and visitors. Staff adhered to the correct principles of 'bare below the elbows', which improves the effectiveness of hand hygiene.

The hospital had an on-site decontamination facility for the endoscopy service. The decontamination room was situated within the endoscopy unit. Staff followed a clear one-way flow of endoscopes between dirty returns and clean dispatch areas to prevent potential contamination.

Endoscopy staff carried out a variety of daily checks. For example, washer disinfector tests, drying cabinet checklist, endoscope reprocessing unit scope tech checks, and water sampling tests. We saw evidence staff conducted these daily and recorded the results. All results we saw for a two-week period in March 2022 were satisfactory.

We saw the most recent Institute of Healthcare Engineering and Estates Management (IHEEM - a professional membership organisation specialising in the Healthcare Estates Sector) inspection report from February 2022. This decontamination review took place in the endoscopy service and concluded as satisfactory.

Environment and equipment

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

Part of the design of the endoscopy environment did not follow national guidance. The unit had carpeted flooring throughout corridors. We saw evidence this was on the risk register and the organisation had plans in place to remove the carpets between July and September 2022.

The endoscopy service had been working towards achieving the Joint Advisory Group (JAG) accreditation. This is a formal recognition that an endoscopy service has showed it has the competence to deliver against certain criteria. Staff told us the service had not yet achieved accreditation due to the flooring.

Endoscopy staff reported the current layout of the endoscopy unit caused some difficulty for patients. For example, those patients waiting to have a colonoscopy did not have sufficiently close access to toilet facilities. Staff told us managers had plans to refurbish facilities in the future.

The IHEEM report noted ventilation flow in the dirty wash side of the endoscopy decontamination unit tested as 'low' in May 2021. The hospital ensured that an additional extract fan was fitted leading to an improvement in ventilation. Repeat testing will be carried out in May 2022.

Equipment was serviced regularly, and we saw evidence of this across the oncology and endoscopy services.

The service had suitable facilities to meet the needs of patients' families. On the oncology unit we saw a 'quiet room' for the use of patients and their families/carers. This room was used for conversations with clinicians and patients or for patients to have some time to themselves. The oncology unit had a comfortable waiting area, which displayed large numbers of information leaflets. Patients and their families/carers had access to a hot drinks machine.

Oncology and endoscopy areas had access to resuscitation trollies. Staff checked the outside of the trollies daily. For example, to ensure they had locked and tagged it correctly. Staff checked the inside of the trollies weekly to ensure all equipment was present and in date. We looked at the checklists and found everything in order and the trollies ready for use in an emergency.

Assessing and responding to patient risk

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

Staff completed risk assessments for each patient on arrival and reviewed this regularly. On the oncology unit they completed medical pre-treatment assessments, and social, emotional and spiritual assessments. On the endoscopy unit staff carried out specific risk assessments in case a patient required Nitrous Oxide (gas and air) for pain relief during a procedure. Staff completed COVID-19 risk assessments for each patient entering the oncology or endoscopy units.

Oncology staff used the UK Oncology Nursing Society (UKONS) screening tool to identify and prioritise patients' clinical issues. The UKONS tool is a risk assessment tool that uses a Red, Amber and Green (RAG) scoring system. Staff told us they directed patients requiring acute oncology support to the local NHS trust or the nearest Accident and Emergency department.

There was an emergency team who responded in case of acute deterioration of patients receiving treatment. At every morning huddle team members were given specific roles within the emergency team. For example, a member of staff to oversee a patient's airway or note-taking.

Staff knew about and dealt with any specific risk issues. Minutes from departmental meetings included discussions of National Institute for Health and Care Excellence (NICE) guidance, policy updates, incident discussions, and Health and Safety aspects. We saw evidence staff discussed clinical aspects such as sepsis and venous thromboembolism (VTE).

Good

Medical care (Including older people's care)

The oncology service had links to local hospice services and GPs. A local cancer charity was based on the unit and helped with signposting patients to end of life care 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 and locum staff a full induction.

Staff rotas were completed months in advance and staff told us teams were flexible in managing any changes.

Nursing staff told us they used the electronic incident reporting system to log and monitor any safety incidents related to staffing. In the six months before the inspection there had been no such incidents reported in oncology or endoscopy.

The heads of department could adjust nurse staffing levels daily according to the needs of patients. Senior staff discussed staffing levels at the daily safety huddle. Staff told us that managers resolved any shortage of staff by redeploying internal staff or using bank or agency staff. Managers tried to limit their use of bank and agency staff as much as possible. When needed, managers made sure all bank and agency staff had a full induction and understood the service.

The oncology unit had three chemotherapy nurses, one clinical nurse specialist for all cancers apart from breast, and one clinical nurse specialist for breast cancer.

Medical practitioners had full clinical responsibility for their patients during the entire clinical pathway. They arranged cover with another medical practitioner who had existing practising privileges in the same specialty should they be unavailable. Eight consultants provided care within the oncology service.

Records

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

The oncology service used a combination of paper and electronic records. For electronic records this was a web-based chemotherapy prescribing platform. This system allowed staff to prescribe Systemic Anti-Cancer Treatment (SACT) and to record assessments and administrative tasks.

Patient notes were comprehensive, and all staff could access them easily. Staff recorded entries in chronological order, legibly and comprehensively. Staff dated and signed all entries and we saw fully completed assessments in the records. Staff stored records securely in offices.

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 risk assessed patients prior to undergoing endoscopy in preparation for the potential use of Nitrous Oxide (gas and air) treatment for pain relief.

Staff stored and managed all medicines and prescribing documents safely. Clean utility rooms had secure doors to avoid unauthorised access. The rooms holding medicines looked tidy. Staff had access to lockable cupboards and fridges to store medicines. A staff member told us pharmacy huddles took place daily on the oncology unit. This was to ensure that all medicines were available for the day's planned treatments.

Good

Medical care (Including older people's care)

Oncology staff reported chemotherapy medication was prepared in Bath the day before a patient's treatment. A distribution company transported the medication from Bath to Banbury. We heard occasionally medication went missing during transit. Staff told us they used a local pharmacy in these circumstances. We saw evidence this issue was on the hospital's risk register. The risk was identified as low in terms of impact on patients. Staff ensured they recorded any incidents of medication lost in transit on the electronic incident reporting system.

Chemotherapy medicine was stored in the main pharmacy department and collected when required. To provide patients with a more seamless service the hospital had plans to move part of the pharmacy to the oncology unit.

The oncology service had access to a cytotoxic spill trolley on the unit and staff had to undergo simulation exercises in case of cytotoxic spillage. Risk assessments relating to the potential exposure to cytotoxic medicine whilst administering chemotherapy were up to date.

We completed a random check of medicine and found none had expired. Staff told us members of the pharmacy team completed regular checks and removed and disposed of all medicine nearing their expiry date.

Staff learned from safety alerts and incidents to improve practice. There had been one medicine incident in the six months before the inspection. This incident did not originate from the hospital (this was an error by a medicine distributor) and did not lead to any harm to a patient.

At the beginning of their treatment patients on the oncology unit received an information pack. This included an emergency telephone contact number for any queries, including pharmacy questions. Patients could access this seven days a week and 24 hours a day.

Staff disposed of hazardous waste safely. On the oncology unit we saw several hazardous waste bins, for example, waste from chemotherapy or infectious waste. These prevented contamination of hazardous waste for both staff and patients.

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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Staff were able to tell us about the most recent incidents. For example, an endoscopy staff member told us about an incident of a patient becoming unwell on the unit. They told us what actions had been taken and how learning was shared with the team.

Managers ensured their teams heard about and learnt from incidents. Staff told us managers discussed incidents in daily unit huddles. Incidents and the learning from these were displayed on notice boards in staff areas.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers ensured they shared all hospital incidents across various meetings. Managers shared all hospital incidents through various staff forums, including meetings and newsletters.

The oncology service recorded 16 incidents in the six months prior to inspection. The majority of those (15=94%) led to no harm or low harm (low harm means that patients may require minor treatment following the incident).

Good

Medical care (Including older people's care)

The endoscopy service recorded 53 incidents in the six months prior to inspection. All of those (=100%) led to no harm or low harm.

Staff met to discuss the feedback and look at improvements to patient care. The scope of the 'learning from incidents forum' included identifying areas of quality improvement to prevent adverse events from happening again. The quarterly hospital quality and safety committee discussed details of incidents, how and why they occurred and what should be done in future to prevent these from happening.

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

Good

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

Evidence-based care and treatment

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

Staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance. The hospital kept track of policies' review dates. All policies in endoscopy and oncology were current.

The endoscopy service used a Local Safety Standard for Invasive Procedures (LocSSIP) based on a National Standard for Invasive Procedures (NatSSIP). This specifically dealt with the World Health Organisation (WHO) surgical safety checklist. The service carried out a monthly records audit against this checklist. Audits for November and December 2021 and January 2022 showed 100% compliance.

The hospital shared relevant national guidelines at a variety of meetings. Managers shared any new or amended National Institute for Health and Care Excellence (NICE) guidance as applicable. We saw minutes from departmental meetings, the clinical governance committee and the quality and safety committee. Evidence-based guidance was a standing agenda item.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients always had access to food and drink. Staff told us they could call catering at any time to request food for patients. For example, patients could ask for gluten-free or vegetarian food options from the hospital menu.

Staff on the oncology unit kept a store of food items on the unit; for example, biscuits. The hospital had a specific menu for oncology patients who required softer food options. Patients had access to refreshments throughout the day. Staff in endoscopy offered patients fluids and food as soon as possible after their procedure. Staff knew some patients had to fast for procedures and ensured nutrition and hydration was offered quickly.

Pain relief

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

Good

Medical care (Including older people's care)

Staff assessed patients' pain and gave pain relief in line with individual needs and best practice. Staff assessed patients' pain at each appointment and before treatment began. We saw completed pain assessments in the records we reviewed.

Patient outcomes

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

The services took part in relevant national clinical audits. We saw clear local audit schedules for the oncology and endoscopy services outlining staff responsible for audits, frequency of audits, and which local policies audits linked to. The hospital based their local audit schedule on the national audits, which demonstrated positive outcomes.

Managers shared and made sure staff understood information from the audits. They used information from the audits to improve care and treatment. Managers discussed findings and outcomes of audits in meetings and made clear plans on how to share these with relevant hospital staff. We saw information on audits displayed on staff notice boards. Staff we spoke with told us about audit activity in their areas.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They implemented action plans following audit completion and ensured they reviewed these when audits were repeated. For example, we reviewed an oncology audit, which clearly outlined any issues found, the actions needed to improve practice and the plan to review actions.

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. There was a competency framework for nursing staff in endoscopy to complete. Medical practitioners worked to specific criteria and conditions outlined in the hospital's Practising Privileges (PPs) policy. This document provided details under which licensed registered medical practitioners were granted authorisation by the hospital director to undertake the care and treatment of patients in a Nuffield Health Hospital.

Managers gave all new staff a full induction tailored to their role before they started work. The programme was comprehensive and included relevant clinical aspects, as well as administrative and environmental features. The hospital included clinical scenarios in the induction of nursing staff. The induction for medical oncology staff included an acute oncology quiz.

On the endoscopy unit new staff received an information booklet to help them prepare for working on the unit. This included team information, clinical information, infection control principles, and relevant resources for new staff to read in preparation for their work. Oncology and endoscopy inductions had checklists included to ensure staff kept track of what they needed to do. As part of their practising privileges, medical staff had to attend induction courses as well as any additional training mandated by the hospital.

Managers supported staff to develop through yearly, constructive appraisals of their work. Nursing staff appraisals included discussions of training identified by the manager or the member of staff themselves and a review of goals. As part of the hospital's practising privileges arrangements, medical staff had to provide evidence of a completed appraisal.

Good

Medical care (Including older people's care)

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Managers displayed the most current meeting minutes on staff notice boards.

Staff had the opportunity to discuss training needs with their line manager and felt supported to develop their skills and knowledge. Staff told us managers gave them study time to attend courses. One senior member of staff reported managers funded external courses if a course was not available in-house.

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.

Multidisciplinary huddles took place daily in both oncology and endoscopy. This helped to ensure services had enough staff for the day, medications needed had been ordered, and staff knew which patients had been booked in for treatment. The hospital shared a daily safety huddle document with staff. We saw examples and it included on call arrangements, safe staffing, and numbers of patients.

Staff told us they had effective links with external agencies, such as GPs, hospices, and the local NHS trust, and conducted formal multidisciplinary meetings for oncology patients.

Seven-day services

Oncology and endoscopy services were not available seven days a week. They operated on weekdays only.

Patients could attend oncology and endoscopy appointments during the week. Oncology patients could call a manned emergency support number with any queries 24 hours a day, seven days a week. The Resident Medical Officer (RMO) carried a phone for patients to contact them any time. The RMO recorded all calls that occurred out of hours in a book on the ward and informed staff a call had been received.

Health promotion

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

Services had relevant information promoting healthy lifestyles and support on their units. On the oncology unit, the charity displayed an information board for patients. We saw guidance on fluid intake for patients with cancer.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records. We reviewed three sets of oncology patient records and saw they included consent documentation. Staff and patients had fully completed and signed these. We observed a booking appointment in endoscopy and heard staff asked the patient for consent before the clinical procedure started.

Good

Medical care (Including older people's care)

Hospital staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. As part of their mandatory training staff had to also complete consent training. At the time of the inspection the compliance rate with training was 96% for mental capacity and deprivation of liberty training, and 95% for consent training.

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

Good

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

Compassionate care

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

The oncology unit had achieved the Macmillan Quality Environment Mark (MQEM) in March 2020. MQEM identifies and recognises cancer environments that provide high levels of support and care for people affected by cancer. The oncology unit achieved an overall score of 5 (=excellent) across the areas assessed against. For example, service experience, and user's voice.

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 a number of interactions between staff and patients. We found them consistently respectful, friendly and kind. Staff used patient names when talking to them.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff ensured they captured information at their first hospital visit. Assessments included spiritual and emotional aspects.

Senior endoscopy staff told us their unit had been awarded an internal Care Award. Consultants working in endoscopy had put this forward as they felt the team was "very friendly, very efficient, and nice to work with".

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. The oncology unit had an established charity that provided free cancer support and information in the UK and online. The charity employees and oncology nursing staff worked together closely to offer advice and support to patients at the hospital. The charity used a room on the oncology unit to have conversations with patients and their families/carers. This included informing patients about their life-changing diagnoses.

We heard staff in the endoscopy unit speaking to a patient who became anxious just before the planned procedure. Staff used a calming manner to support the patient and the procedure could go ahead.

Understanding and involvement of patients and those close to them

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

Good

Medical care (Including older people's care)

Staff made sure patients and those close to them understood their care and treatment. Patients had named consultants who followed them through their pathway. We spoke with two oncology patients who said they felt well informed throughout their treatment. They reported they had access to three telephone numbers for emergencies and general queries about their treatment. They had used this route and had a good response.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw two oncology patient satisfaction surveys from April and May 2021. The questions centred around practical (car parking, signage), staff support, and privacy and dignity. Patient responded overwhelmingly positive. In the endoscopy service we saw patient leaflets explaining how to give feedback and the importance of it.

Patients gave positive feedback about the service. We saw many cards that patients had written to endoscopy and oncology staff thanking them for the care they had received.

The oncology unit had two side rooms. Staff encouraged patients to receive treatment in the large treatment room to socialise with staff and other patients. However, patients could use the side rooms if they preferred to be alone during treatment.

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

Good

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

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

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

Managers planned and organised services, so they met the changing needs of the local population. The hospital used to run patient forums to gather feedback from the local population. During the pandemic the hospital had to pause this; however, plans were in place to re-start forums in May 2022.

Facilities and premises were appropriate for the services being delivered. The oncology unit was tastefully decorated and bright. The hospital had recently refurbished one side room and opened it up to allow for more treatment chairs. One patient told us treatment chairs were comfortable and could be reclined. Patients in wheelchairs could access treatment areas.

The hospital had on-site underground parking facilities. Patients could access the main hospital via stairs or lifts. Patients could access endoscopy and oncology units on foot, in a wheelchair, or via lift. The hospital had good signage to help patients find their way.

Through the cancer charity based on the oncology unit, patients could access various cancer-specific groups.

The service had systems to help care for patients in need of additional support or specialist intervention. The hospital stocked Easy Read booklets. Staff told us services could be flexible when patients with additional needs visited. For example, staff allowed the daughter of a recent patient with short term memory loss to attend treatment. Both the patient and their daughter used a side room for treatment.

Good

Medical care (Including older people's care)

Meeting people's individual needs

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

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The population of the hospital was mainly English-speaking. However, the hospital had access to interpreters if needed. Interpreters worked over the telephone. Patients from abroad had access to a face-to-face translator who accompanied the patient throughout their pathway.

The oncology service had specialist equipment available. For example, we saw scalp cooling caps for patients' use in the equipment store.

Patients were given a choice of food and drink to meet their dietary preferences. This included patients who required gluten-free or soft foods.

Services had set up links with relevant services in the community to allow for a smooth patient journey. Services communicated with GPs and hospices when required.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Oncology staff told us there was currently no waiting list. Patients accessed the service quickly following referral.

Oncology staff gave chemotherapy patients a choice of appointment times, while at the same time they ensured there was flow through the unit. In the endoscopy unit we saw good flow of patients. We did not see patients who had to wait long for their procedure.

For the period of March 2021 to February 2022 the oncology service had to cancel one appointment. This was due to the delay of their chemotherapy medication. In the same time period, the endoscopy service cancelled 27 appointments. Ten cancellations occurred at the patient's request (=37%). The remainder of cancellations were due to a variety of reason such as COVID-19, or the procedure no longer being required.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. They had several ways of raising concerns. These included completing a patient satisfaction survey questionnaire, hospital website forms, written or verbal complaints. The hospital stocked complaint forms in various locations across the site.

Staff understood the policy on complaints and knew how to handle them. Both oncology and endoscopy services had folders in staff offices holding information on complaints. The hospital firmly stated patients should be given the opportunity to talk to a senior member of the team and given a leaflet about how to complain.

Good

Medical care (Including older people's care)

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

The hospital had not referred any complaints to the Independent Sector Complaints Adjudication Service in the 12 months prior to inspection. It had been possible to deal with all complaints within the internal complaints process.

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

Good

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

Leadership

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

Staff told us managers were approachable and visible and had an “open door policy” to discuss concerns.

Oncology staff told us senior leaders visited the unit daily to check on the team’s wellbeing. Staff described feeling supported by senior leaders.

The service had leadership and organisational structures with clearly defined roles, responsibilities, and accountabilities in place.

Vision and Strategy

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

Staff we spoke with were aware of the hospital and services vision and could demonstrate their role to improve patient services for the future. Nuffield Health had a strategy underpinning this vision.

For detailed information on this, please see the surgery part of this report.

Culture

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

We saw a positive staff culture across the service. Teams appeared nurturing and professionally supportive of each other.

The service had an up to date equality, diversity and inclusion policy in place.

Good

Medical care (Including older people's care)

Managers ran a care forum for staff with representatives from all areas of the hospital. This gave staff an open forum for engagement and discussion about staff wellbeing.

Managers created an employee recognition scheme in place. Staff could nominate colleagues for an award if they had shown the company's values in their work.

Staff told us there was an "open door" approach with senior managers to discuss ideas or concerns. For staff who preferred, there was a possibility to leave anonymous feedback in an internal letterbox. Managers regularly checked the letterbox.

Governance

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

The service had a clear governance structure in place with committees, such as the quality and safety committee and the clinical governance committee. Senior staff attended hospital-wide governance meetings.

The clinical governance committee met monthly and the minutes showed discussions on findings from audits, reported incidents and complaints took place. Staff attended monthly team meetings where action plans and timelines for completion and learning from incidents and complaints were discussed.

The service had a rolling audit programme with clear timescales, frequency of audits and staff responsibilities.

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.

Staff reported risks to heads of department who escalated them to the senior team as required. Endoscopy and oncology had their own local risk registers. Minutes from various committee meetings showed risks as a standing agenda item. Staff regularly reviewed risk ratings and progress on action plans to mitigate risk.

For detailed information on this, please see the surgery part of this report.

Information Management

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

For detailed information on this, please see the surgery part of this report.

Engagement

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

For detailed information on this, please see the surgery part of this report.

Good

Medical care (Including older people's care)

Learning, continuous improvement and innovation

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

For detailed information on this, please see the surgery part of this report.

Good

Services for children & young people

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

Are Services for children & young people safe?

Good

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

Mandatory training

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

The mandatory training was comprehensive and met the needs of children, young people and staff. Staff received training that was specific to their role and caring for children and young people, for example paediatric life support. Staff were allocated time to complete their training.

Staff received and kept up-to-date with their mandatory training. Completion rates for mandatory training were 100% for all subjects, apart from two, basic life support, 75% and practical manual handling, 83%. These were face to face sessions and compliance had been impacted by the pandemic. The Regional Medical Officers had paediatric advanced life support training and were on site 24 hours a day, seven days a week.

Managers monitored mandatory training and alerted staff when they needed to update their training. The paediatric lead nurse monitored compliance and sent email reminders to staff whose training expiry dates were approaching.

Safeguarding

Staff understood how to protect children, young people and their families 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 could give examples of how to protect children, young people and their families from harassment and discrimination. Staff were trained in both adult and children's safeguarding, including female genital mutilation and child sexual exploitation, in accordance with their job role, as stated in national guidance. Safeguarding training included subjects such as self-harm and domestic abuse. Staff demonstrated their understanding of safeguarding warning signs and their responsibilities in reporting and following up queries or concerns. Staff across the service advised they were encouraged to be "Professionally curious". Staff received a monthly safeguarding bulletin. Staff were in the process of receiving LGTBQIA2S+ paediatric safeguarding training that would provide understanding of specific safeguarding concerns experienced by this group and how staff and

outside agencies could support children and young people presenting with these. The paediatric lead nurse had already completed this training and was developing a gender diversity communication and training folder to ensure staff used up to date terminology and language. The service displayed safeguarding boards that included posters about internet and online safety, as well as safeguarding awareness information.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff received training from and worked well with the Oxford Safeguarding Board. Staff had access to an electronic system that alerted when a child or young person was known to social services and safeguarding teams.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff knew the children's safeguarding lead was the paediatric lead nurse and staff advised us they felt comfortable going to them with a concern. Staff followed safe procedures for children visiting the ward. The services children's safeguarding policy included children who visited the hospital as well as children who were receiving treatment.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. All areas of the ward and consulting rooms was visibly clean.

The service generally performed well for cleanliness. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The latest hand hygiene audit result was 98%. Cleaning records and checklists were up to date, signed and dated.

Staff followed infection control principles including the use of personal protective equipment. Staff could access personal protective equipment, such as gloves and aprons in a range of different sizes and wards were fully stocked. We saw staff donning and doffing personal protective equipment in accordance with the hospital's policy.

Staff cleaned equipment after usage and labelled equipment to show when it was last cleaned. Staff provided children and young people with toys that were wipeable when they were shared with other children and young people. Staff deep cleaned the inpatient playroom between usage. Staff in outpatients arranged toys into boxes. Children and young people took toys out of the 'clean' box and placed them into the 'dirty' box when they were finished. All equipment checked had 'I am clean' stickers with the date they were cleaned.

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.

Staff carried out daily safety checks of specialist equipment. Staff completed daily checks of the resuscitation trolley to ensure the trolley was fully equipped with age appropriate equipment and batteries were fully charged in order that it was ready for use in the event of an emergency. We checked 10 items of equipment, all had been serviced within the last 12 months, we saw staff check equipment was clean and serviced before use.

Good

Services for children & young people

The service had suitable facilities to meet the needs of children and young people's families. The service ensured children and young people's clinics were secure. The inpatient ward had locked access from the main hallway and kept visitor lists for who children and young people and their families accepted as visitors. Outpatients arranged children and young people's clinics for set times when no other adult led clinics were being held. Children and young people had access to a separate recovery area that was fully stocked with age appropriate equipment.

The service had enough suitable equipment to help them to safely care for children and young people but stock checking systems were not effective. Staff advised us the service had enough equipment to meet the needs of children and young people, if a need for new equipment was identified, the paediatric lead nurse was quick to place an equipment order. We checked the medical consumables stock in the inpatient ward and found four items out of date. This was reported to the paediatric lead nurse and the items were immediately removed and destroyed. Staff showed us that consumables were checked and signed off monthly, however one of the items was out of date by two years. Managers had not ensured checking systems were effective.

Staff disposed of clinical waste safely. Managers clearly displayed the clinical waste policy for staff to follow. Clinical waste was stored securely and collected and destroyed by a third party contractor.

Areas of the environment did not follow national guidance. Three of the six inpatient bedrooms were carpeted, which was not in line with Health Building Note 00-09: 3.115. The risk of carpeting in clinical areas was reviewed regularly, noted on the departmental risk register and plans were in place to refurbish the carpeted areas, this had been delayed after a corporate review. Staff cleaned carpets daily and allocated rooms without carpeting as a priority. Managers mitigated risks well whilst waiting for the refurbishment to take place.

Assessing and responding to children and young people's risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. Staff used Paediatric Early Warning Score (PEWS) records in accordance with children and young people's ages, for example there were three separate PEWS documents, one for children aged one to four, another for aged five to 11 and a 12 plus record.

Staff completed risk assessments for each child and young person on admission / arrival, using a recognised tool, and reviewed this regularly. Staff completed assessments for all areas of risk, for example, pressure areas and falls. For planned surgery, children and young people took a Covid-19 test three days prior to admission, if the test was positive the surgery was rearranged. If the test was negative, children and young people and their families isolated for the three days before admission and took a lateral flow test on the day of admission.

Staff knew about and dealt with any specific risk issues. The service had clear comorbidity criteria detailing the children and young people who could safely be treated at the hospital. The only comorbidities accepted by the service were asthma. This meant the hospital only admitted children and young people they had the facilities and expertise to care for. Staff completed sepsis training, there was a sepsis box and staff displayed sepsis awareness posters. Staff accompanied children and young people throughout the surgery process including going to theatre, during surgery and remained on a one to one basis during recovery. The service always had at least one member of staff on duty who was qualified in advanced children and young people's service life support. Staff followed hospital policy if a child or young person became critically ill. The hospital was located opposite the local NHS hospital and children and young people were transferred to the hospital accident and emergency department in an emergency.

Good

Services for children & young people

Shift changes and handovers included all necessary key information to keep children and young people safe. Handovers were detailed, included a review of care given, potential risks, medicines and demeanour. When children and young people were admitted, the lead nurse and senior nurses met with theatre staff to discuss the specific needs of the child.

Nurse staffing

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

The service had enough nursing and support staff to keep children and young people safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, in accordance with national guidance. The paediatric lead nurse was responsible for ensuring there were enough staff to cover shifts. The service had a staffing ratio of one registered children's nurse to three inpatients. There were two registered children's nurses in the hospital when children were admitted. A ward sister, two full time and one part time senior nurses and one full time and one part time play assistants supported the service.

The ward manager could adjust staffing levels daily according to the needs of children and young people. Staff were flexible and worked around the surgical and outpatient clinical lists. The number of nurses and healthcare assistants matched the planned numbers. We checked staff rotas and saw planned numbers matched actual numbers of staff.

Managers limited their use of bank staff and requested staff familiar with the service. Managers made sure all bank staff had a full induction and understood the service. The service was supported by 10 regular bank staff who were children's nurses.

Medical staffing

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

The service had enough medical staff to keep children and young people safe. Managers ensured all medical staff completed a request for children and young people's admitting rights. This information was used by the hospital management team to determine whether the person had the required skills and experience to provide a children's service at the hospital. Medical staff who could not demonstrate they had the relevant skills were not granted practicing privileges. All children and young people were admitted under a named consultant in line with guidance.

The medical staff matched the planned number. The booking team had initial responsibility for planning medical staff numbers around booked surgery and clinics. The paediatric lead nurse had responsibility for checking the service had adequate medical cover, including consultants and anaesthetists. We checked staff rotas and saw planned numbers matched actual numbers of staff.

The consultant who admitted the child or young person was responsible for their care during their length of stay. There was a resident medical officer with paediatric experience on-site 24 hours a day, seven days a week.

Records

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

Good

Services for children & young people

Children and young people's notes were comprehensive and all staff could access them easily. We reviewed 10 sets of children and young people's records and found them to include the relevant assessments of care needs, risk assessments and were and personalised. All medical and nursing notes were held within the one document to ensure staff had access to all information. The service now consistently documented pain scores, discharge scores and ensured children and young people's records were signed and complete. Managers audited 10 random children and young people records each month. Audit scores for the few months prior to inspection were in the high 90's. Where errors had occurred or emerging themes seen, these had been highlighted and an action plan put in place for improvement. Records were stored securely. Children and young people's records were stored away from communal areas in locked cabinets.

Medicines

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

Staff followed systems and processes to supply, prescribe and administer medicines safely. The hospital had an on-site pharmacy that was responsible for the supply of medicines. Staff told us pharmacy staff provided a good service and were available and accessible when needed. The pharmacy department audited medicines, the most recent result was 94%.

Staff reviewed each child and young person's medicines regularly and provided advice about their medicines. Medicines were reviewed by the child's or young person's consultant and discussed at multidisciplinary meetings. Children and young people were given information leaflets for any prescribed take home medicines for post discharge.

Staff completed medicines records accurately and kept them up-to-date. We reviewed 10 set of medicines records and found them to be detailed and clear.

Staff stored and managed all medicines and prescribing documents safely. Staff stored medicines and prescribing documents in a secure, locked room. The pharmacy department monitored medicine storage temperatures centrally and a system alerted the team if temperatures dropped out of range. The service had effective systems and processes to follow if storage temperatures dropped out of range.

Incidents

The service managed children and young people's 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 children, young people and their families honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with policy. Staff demonstrated the electronic incident reporting system. All staff we spoke with knew their responsibilities in reporting incidents and near misses and how to access policies.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation if and when things went wrong. Staff we spoke with could describe their responsibilities regarding duty of candour. Service responses to incidents acknowledged the issues and concerns raised and followed duty of candour guidelines.

Staff received feedback from investigation of incidents. Incidents were discussed at team meetings. Staff met to discuss the feedback and look at improvements to children and young people's care. There was evidence that changes had been made as a result of feedback. A review of incident trends in inpatients found tympanoplasty day cases that were booked for surgery in the afternoon usually required an overnight stay. In response to this incident, this surgery was only booked

Good

Services for children & young people

for morning theatre slots and two paediatric nurses were put on stand-by to work the night shift if an overnight stay was required. In outpatients, an anaphylaxis box had been updated to include an epinephrine autoinjector (epi pen) after a child had a reaction to a skin prick whilst they had chicken pox. Staff now documented children and young people's weight and height information after learning from an incident, managers audited this process to ensure it was adhered to.

Are Services for children & young people effective?

Good

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Managers reviewed policies regularly to ensure they were up to date and followed best practice and guidelines such as National Institute for Health and Care Excellence.

Staff knew where to access policies and signed to show they had read and understood the content. Managers used audits to check staff followed guidance and used action plans to review improvements to practice. Plans were re-audited to monitor effectiveness.

Nutrition and hydration

Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. The service made adjustments for children, young people and their families' religious, cultural and other needs.

Staff made sure children, young people and their families had enough to eat and drink. The service provided three meals a day and snacks and drinks were also provided throughout the day. Visitors could join children and young people for meals with advanced noticed.

Staff fully and accurately completed children and young people's fluid and nutrition charts where needed. We reviewed 10 sets of food and fluid charts and found all were up to date, fully completed and included information such as allergies and where appropriate followed Association of Anaesthetist guidelines for fasting. Staff used a nationally recognised screening tool to monitor children and young people at risk of malnutrition. Staff assessed children and young people at risk of becoming malnourished. The screening tool was completed as part of the admission process to ensure staff had access to information as soon as possible.

Pain relief

Staff assessed and monitored children and young people 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.

Good

Services for children & young people

Staff assessed children and young people's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff assessed and monitored their pain throughout the care process. Staff used various age appropriate nationally recognised tools for measuring pain, for example, smiley and sad faces were used for children that may not be able to describe their pain but could point to a picture.

Children and young people received pain relief soon after requesting it. Staff regularly checked children and young people's pain levels and were quick to administer pain relief and review whether the pain relief provided was effective.

Staff did not always document pain relief accurately. The most recent spot check of pain records showed 82% compliance with documentation. Staff were checking and administering pain relief effectively, but not fully completing the documentation. Managers had created an action plan to improve staff compliance.

Patient outcomes

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

Managers and staff carried out a comprehensive programme of repeated audits to review patient outcomes. Managers used information from the audits to improve care and treatment. Managers shared outcome data with staff and areas of improvement were checked and monitored. The service analysed children and young people's outcome data, such as inpatient and outpatient activity, unplanned returns to theatre, unplanned transfers to other hospital and avoidable cancellation on the day of surgery to monitor trends and improve the quality of the service. We viewed data from the 6 months prior to inspection and all was positive and higher than the national average. Meeting minutes showed children and young people's outcome data was discussed in the quarterly governance meetings.

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 children, young people and their families. The paediatric lead nurse had accountability for all the children's services including both inpatients and outpatients. The hospital director reviewed practicing privileges every other year, as part of the process, consultants were required to demonstrate competency.

Managers gave all new staff a full induction tailored to their role before they started work. Managers developed tailored induction packages for each job role in the department. These included competency checklists. New staff worked across the service during their induction in order to get a better understanding of how the hospital worked as a whole and highlight any areas of interest or development.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff used appraisal as an opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. At the time of inspection all employed staff within the children and young people's department had received an appraisal within the last 12 months. Staff advised us the paediatric lead nurse supported them to develop their areas of interest, the service had developed staff ambassadors for 10 areas, including; hearing impairment, autism, tissue viability and medical devises.

Good

Services for children & young people

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Team meetings were arranged around staff shifts and the requirements of the service to ensure as many staff as possible could attend. The paediatric lead nurse ensured minutes were available to all staff and arranged the next meeting around those who could not attend the previous meeting.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

Staff worked well across multidisciplinary teams to support children and young people and improve their care. Staff we spoke with told us there was effective working between all staff groups. All staff we spoke with told us staff in the hospital worked as a team to support children and young people. We observed effective, friendly and helpful interactions between all staff working at the hospital.

Seven-day services

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

Staff could call for support from doctors and other disciplines, including diagnostic tests, 24 hours a day, seven days a week. The resident medical officer was on site 24 hours seven days a week and was therefore available at night and at weekends. The diagnostic imaging department was available between 8am and 5pm weekdays. During the weekend and overnight, radiographers provided an on-call service. The hospital pharmacy service was available between 9am and 5pm Monday to Friday. During the weekend and overnight, pharmacy staff provided an on-call service.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support. Throughout the department staff displayed posters promoting a healthy lifestyle in age appropriate formats, for example an activity pyramid and healthy diet diagrams, mental health, dental and wellbeing boards.

Consent and Mental Capacity Act

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff made sure children, young people and their families consented to treatment based on all the information available. Staff ensured consent was documented by children and young people where plastic surgery was being undertaken to ensure it was what the child wanted. In these instances, family were not present during discussions to prevent coercion. One parent advised us they felt their child had “Taken ownership” of their procedure. Staff gained consent from children, young people or their families for their care and treatment in line with legislation and guidance. Consent forms referenced up to date legislation from the Department of Health. Staff clearly recorded consent in the children and young people's records. We checked 10 records and found benefits, risks and consent was clearly recorded on all documentation. Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff received training in understanding Gillick competencies and understood when to gain consent from a parent or child. Consent forms included the competency principles which staff had to co-sign. Audited results for consent documentation shown 95% compliance, there were plans to increase this to 100%. Staff displayed posters promoting the availability of chaperones in both outpatients and inpatients.

Good

Services for children & young people

Clinical staff completed training on the Mental Capacity Act, achieving the trust's target. Mental capacity act training formed part of the staff mandatory training programme. All staff working in the service were up to date with Mental Capacity Act training. Staff could describe and knew how to access the policy and get accurate advice on the Mental Capacity Act. The service followed the Nuffield Health corporate policy when reviewing and acting on behalf a children and young people under the Mental Capacity Act.

Are Services for children & young people caring?

Outstanding ☆

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

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Feedback from children and young people was overwhelmingly positive about the way staff treated people. Children, young people and their families said staff treated them well and with kindness. We saw 74 children and young people satisfaction surveys, all noted positive experiences of being at the hospital. On site, families advised us they were "More than happy to have my child come here" and "Staff here are brilliant".

There was a strong person-centred culture. Relationships between children and young people, families and staff were caring, respectful and supportive. Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. We observed positive, friendly interactions between staff, children and young people and their families.

Staff recognised and respected the holistic needs of children and young people. Staff took personal, cultural, social and religious needs into account, and found innovative ways to meet them. Staff adapted an unused inpatient bedroom into a prayer room for a Muslim child and their parents in order that they had somewhere to pray during their stay. Staff built relationships with local faith leaders and could contact them for support if a child or young person or their family required it.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their families, wellbeing. Care plans followed National Institute for Health and Care Excellence NG204 principles, including, Hear Me, Support Me, Take Care of Me, Understand Me, Talk to Me, Involve Me, Respect Me, Ask Me, Help Me Understand and Help Me Feel Comfortable, these principles underpinned the caring culture of the department. The service aligned staff shifts as much as possible to ensure the staff who supported the children and young people and their families during pre-assessment, were on shift for the day of surgery. Staff were allocated to support the children and young people at admission to provide continuity of care. Post discharge, the staff member who looked after the child or young person whilst on site telephoned a week later to check in with them and ensured they were alright and provided another opportunity to ask questions.

Good

Services for children & young people

Staff gave children, young people and their families help, emotional support and advice when they needed it. Staff provided all children and young people with a soft toy that was the child's to take home. Children and young people and their families advised us they appreciated the gesture. Staff used the playroom or area to a provide a friendly environment to complete observations for children and young people who were nervous or anxious. Staff advised us children and young people were more relaxed and staff could record more accurate results. Staff provided children and young people with a bravery certificate after a procedure. Families advised us children were very proud to receive these.

Staff understood the importance of supporting children and young people with extra needs for example, autism or phobias. Staff supported the surgery of a non-verbal, violent child, by completing a detailed and holistic care plan. The plan reviewed staffing levels and ensured the child received continuous one to one care, adapted the environment to remove all breakables and ligature points and ensured no other children and young people were on the ward during their stay. The feedback from family was that it was the best hospital experience they had ever received.

Staff asked for information about phobias at the telephone pre-assessment. If a child or young person had a phobia or a learning disability, staff completed another onsite assessment to reviews ways of supporting prior to surgery or their appointment. For example, staff supported a child with a phobia of cannulas by allowing them to see and play with the cannula, staff discussed how it worked and answered questions prior to admission. Another child was scared of surgery, staff arranged a theatre walk through, the child met the surgical team and was able to ask staff questions about the process. If a child required a bandage or plaster, they practiced applying one to a toy beforehand.

Staff adapted methods of working for children and young people with learning disabilities, for example, staff had found children and young people were scared of the electronic blood pressure machine, therefore staff had reviewed their competencies to take blood pressure using the manual equipment. Staff had developed specialist colouring books for autistic children, which studies have shown helps to calm down children and young people who are autistic or who are anxious.

Understanding and involvement of children and young people and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Children and young people and their families were active partners in their care and staff were fully committed to working in partnership with them. Children and young people's individual preferences and needs were reflected in how care was delivered.

Staff made sure children, young people and their families understood their care and treatment. The service produced a variety of information leaflets in different formats appropriate for a range of age groups. For example, in order to explain how anaesthesia works, there was a detective comic for young people and a bear story for children. Children also received a 'When Nuffy Met Sam' story book explaining the hospital admission and discharge process.

Staff talked with children, young people and their families in a way they could understand, using communication aids where necessary. We observed staff explain to children, young people and families their planned procedures. Staff described them in plain English at an appropriate level for the child to understand, why the procedure was needed and what it would feel like. Staff ensured children and young people and their families had several opportunities to ask questions. Staff showed children and young people how to correctly wear face masks by covering a Disney character cardboard cut-out with a mask over their ears, mouth and nose. Posters were available in age appropriate formats, for example hand hygiene posters used bear characters to support understanding of younger children.

Good

Services for children & young people

Are Services for children & young people responsive?

Good

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

Service delivery to meet the needs of local people

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

Facilities and premises were appropriate for the services being delivered. There was a dedicated 6 bedded area where children admitted to the hospital were cared for. Two of the six bedrooms had pull out beds for a family member to stay in overnight, there were plans to provide these for the other four rooms. The inpatient ward and outpatient department both had a dedicated children's play area. The operating department had a separate children's recovery room. Outpatients did not have a separate children's waiting area, although plans were in place to provide one. In the meantime, clinics were arranged in blocks to prevent adult clinics taking place at the same time as children's clinics.

Managers monitored and took action to minimise missed appointments and ensured that children, young people and their families who did not attend appointments were contacted. The booking team contacted children and young people and their families three days prior to appointment or admission to remind them of the appointment and ensure they had taken a Covid 19 test. The service was developing a new system to monitor children and young people that missed appointments and ensure follow up was quicker. This was not in place at the time of inspection, there was no formal process for following up missed appointments.

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services.

There was a proactive approach to understanding the needs and preferences of different groups of children and young people and delivering care in a way that met these needs.

The service was designed to meet the needs of children, young people and their families. The services pre-assessment process was detailed and provided staff with enough time to adapt the environment to support the needs of children and young people. The service allowed patients to wear their own clothes to surgery if these were appropriate. Information regarding appropriate attire was provided at pre-assessment and depended on the procedure. Staff provided age appropriate hospital gowns if clothing was not provided to wear to theatre. Staff requested information regarding children and young people's likes and dislikes during the pre-assessment process to ensure staff had enough time to personalise bedrooms. Children and young people were provided personalised name signs for their room, personalised bedding, toy preferences and DVD preferences. One child liked dinosaurs and princesses; staff adapted their bedroom to include items that were a mix of the two. Young people who were 17 years old had the option of being treated in the children's or adults inpatient ward.

Managers made sure children, young people and their families could get help from interpreters when needed. Staff ensured a translator was available when a child or young person's first language was not English was attending the service. Information leaflets, discharge packs and clinical tools were available in Greek, Arabic and Spanish.

Good

Services for children & young people

Children, young people and their families were given a choice of food and drink to meet their cultural and religious preferences. Staff assessed catering requirements during the pre-assessment process. The hospital kitchen could accommodate all dietary requirements whether cultural or religious.

Access and flow

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

Managers and staff worked to make sure children and young people did not stay longer than they needed to. Children's surgical procedures were booked for day case procedures at the beginning of theatre lists, which usually meant children and young people could recover and return home the same day. Managers reviewed day case conversion to overnight stays on a case by case basis.

Managers monitored waiting times and made sure children, young people and their families could access services when needed. Bookings were undertaken on an individual case by case basis. Pre-assessment clinics ran three days a week, Monday, Thursday and Saturday. Pre-assessment took place a minimum of seven days before planned surgery to ensure staff had time to plan to meet their needs. Pre-assessment and discharge packs were tailored to individual age groups and included age specific side-affects and any areas of concern families should monitor.

For outpatient booking systems, please see outpatients.

Managers and staff started planning each child and young person's discharge as early as possible. Staff reviewed discharge planning as part of the pre-assessment and admissions process. This was also reviewed daily by the named consultant. The service followed the providers policies and procedures regarding admission and discharge. The service had a booking process for appointments and hospital admissions. Parents we spoke with told us the hospital had a good and efficient booking process. Children and young people using the service were added by the booking team to the hospital's patient information management system. This meant that children and young people's details and appointments could be tracked by staff working throughout the hospital.

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 children, young people and their families in the investigation of their complaint.

Children, young people and their families knew how to complain or raise concerns. Families and children and young people we spoke with told us they knew how to make a complaint if needed. Staff included feedback forms in all discharge packages and encouraged children and young people and their families to provide feedback regarding their care, these were age appropriate. The service clearly displayed information about how to raise a concern. Complaint forms were clearly displayed in reception areas, waiting rooms and inpatient bedrooms. The services website clearly showed children and young people and their families how to complain and detailed the complaints process.

Staff understood the policy on complaints and knew how to handle them. The service followed the Nuffield Health corporate complaints policy when investigating and responding to complaints or concerns. The hospital director had overall responsibility for the management of complaints. Staff received conflict resolution training and told us they always tried to address complaints or concerns immediately to see if they could be addressed by the team. We saw evidence of hospital complaints being discussed in the minutes of the monthly governance meetings.

Good

Services for children & young people

Managers investigated complaints and identified themes. Staff could give examples of how they used children and young people's feedback to improve daily practice. The children's feedback form previously consisted of tick boxes. Managers reviewed this after a complaint at the weekly service review. In response, staff adapted the form to include a comments section and a picture section to ensure young children that could not yet write, still had a method for communicating feedback.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff received feedback from complaints at team meetings and 'You said We did' boards clearly detailed the department's response to complaints about the service.

Are Services for children & young people well-led?

Good

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

Leadership

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

The service was run by the paediatric lead nurse who had accountability and oversaw all the children's services at the hospital. There was also a lead paediatrician consultant who represented the service at the Medical Advisory Committee and the lead paediatric anaesthetist coordinated anaesthetist's availability for children's theatre lists.

The provider, Nuffield Health, arranged for a senior children's lead nurse to provide umbrella support to all Nuffield hospitals with a children's and young people's service, as well as a network where hospitals that provided children's services supported one another. All staff we spoke with praised the leadership team, especially the hospital's paediatric lead nurse.

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 children and young people's service had a clear vision that was linked to the hospital's strategy. However, this had not yet had a chance to filter down to the department and staff were yet to buy in to the vision.

Staff we spoke with were unsure of the vision and strategy for the department or hospital. Department leads produced a plan to embed the vision and strategy within the department, however this was still in its early stages at the time of inspection.

Culture

Staff felt respected, supported and valued. They were focused on the needs of children and young people receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development.

Staff advised us that well-being and the mental health of staff was very important to the paediatric lead nurse and they supported staff to have a good work/life balance.

Leaders took the time to find out staff interests and created opportunities for staff to develop in those areas. One nurse loved teaching, within a year of working at the hospital they had completed three train the trainer courses and was teaching other staff in the department.

Staff comments regarding the culture of the service included; “Matrons door is always open”, “Our lead nurse and Matron are very approachable”. “This is a lovely place to work”. “I feel like part of a team”.

Governance

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

The service had clear lines of governance structure, roles, responsibilities and accountabilities. Staff knew who and what they were responsible for.

The governance lead completed a weekly review of incidents and complaints. There was a children and young people quarterly clinical governance meeting attended by two consultants including the medical advisory committee chair, a paediatrician, and representatives from the radiology department and pharmacy, the paediatric lead nurse and matron. Agenda items included; incidents, admissions, medicines review, safeguarding referrals and a review of the risk register. Areas of improvement were reviewed and plans implemented with an accountable person and completion/review date.

The Children and Young Peoples Services Committee met quarterly to review quality improvement, and review regulations and clinical audit. The committee included representatives from across the hospital’s children and young people’s services.

The service completed a quality assurance review in 2021. The review was based on a Care Quality Commission report and each area was rated. The report included recommendations for improvement, including developing a pathway for endoscopy that was specific for children and young people. We saw managers were developing this at the inspection.

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.

Performance was also reviewed through an audit programme that was reviewed quarterly. Where action plans and changes to policy and practice were introduced, audits were repeated monthly to monitor improvement. For example, note reminders for anaesthetists for prescribing oxygen.

The risk register for the service was reviewed monthly at leadership meetings. The risk register reflected the concerns identified by managers and staff, for example the carpet in three of the inpatient clinical rooms. Although the carpets had been risk assessed and were regularly deep cleaned to reduce the IPC risk.

Good

Services for children & young people

Information Management

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

For information management, please see surgery.

Engagement

Leaders and staff actively and openly engaged with children and young people and staff to plan and manage services.

Managers reviewed results from monthly staff questionnaires regarding working at the hospital and wellbeing. A social day was organised in response to questionnaire results.

Staff received daily update emails which celebrated departmental achievements across the hospital. Managers sent a monthly bulletin that summarised the previous months performance and any themes or awareness taking place at the hospital, for example safeguarding and quality assurance. Staff we spoke with enjoyed participating in the 'We Care' nomination cards and the Nuffield Values Recognition Award.

Children and young people forums were bi-monthly before the pandemic, the service was reintroducing these in the spring. These were attended by both parents and children and young people. Staff evidenced changes to feedback via the 'You Said, We Did' board, for example, more fruit was added to menus.

Learning, continuous improvement and innovation

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

Managers displayed 'bright ideas' posters across the service to encourage staff to share ideas they believed would improve the service.

The service was developing a children and young people endoscopy pathway and structure in order that they could provide the service.

Requires Improvement

Diagnostic imaging

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

Are Diagnostic imaging safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff. However, we saw that not all staff had completed this.

The mandatory training was comprehensive and met the needs of staff and some patients. Training was delivered through a mixture of online and classroom based sessions. Training in health safety and welfare and also managing sharps formed part of mandatory training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us that they received emails when training was approaching a renewal date.

Staff and managers, we spoke with told us staff were able to complete their training and time would be allocated for this.

However, records provided by department show that staff did not keep up-to-date with their mandatory training. The overall staff training compliance for the department was 62%, the target for the service was 95%. Staff compliance for training in basic life support was 29% with only 4 of 14 eligible staff having completed this training. In addition to this, compliance with manual handling was 64%.

There was mandatory training on the Mental Capacity Act, however compliance with this training was 57%.

Clinical staff did not complete any specific training on recognising and responding to patients with learning disabilities, autism or dementia.

Safeguarding

Staff had some training on how to recognise and report abuse, but the level of training did not meet national guidance. Safeguarding training formed part of mandatory training, however all staff had not completed this.

Diagnostic imaging

Staff received some training specific for their role on how to recognise and report abuse. Clinical staff completed level 2 adult safeguarding training, compliance with this training was 71%, this was below the target of 95%.

The compliance with training in safeguarding level 1 for children was 71%, this was below the target of 95%. Although training compliance did not meet the service's target, staff were aware of their role and responsibilities in making safeguarding referrals. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

However, children's safeguarding training expectations were not in line with the national intercollegiate document: Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (fourth edition: January 2019). This document provides a clear framework which identifies the competencies required for all healthcare staff. The document states that Diagnostic radiographers will require minimum of level 2 safeguarding training. Clinical staff received children's safeguarding training to level 1, this was despite the department performing procedures on paediatric patients.

The provider level policy states that only sites providing solely paediatric services required level 2 safeguarding training, this is in direct conflict with the intercollegiate guidance which states those involved full time or significantly in paediatric radiography require level 3.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were aware of their role in keeping patients and others safe and were able to give examples of scenarios that may indicate a patient, or if others were at risk.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We spoke to staff told us how they had raised safeguarding concerns and the process they followed.

Staff followed safe procedures for children visiting the department. There was clear signage in waiting areas that explained that parents and carers should remain with their children in waiting areas. Radiographers were able to explain how they would allow parents to accompany their child into the scan room and leave when radiation was present. Children were always accompanied by a parent or carer and were able to wait with them.

At the time of the inspection, there were restrictions on patients bringing additional persons to their appointments to reduce footfall in line with COVID-19 infection prevention hospital policy. We were told that if a parent has brought a child to an appointment then when the parent went in for a procedure, a member of staff would wait with the unaccompanied child until the parent returned.

However, there were no signs regarding the requesting chaperones in the waiting area. This would be most appropriate for sonographic scanning that may involve an internal scan but also for any procedure where the patient requests this.

Cleanliness, infection control and hygiene

The service did not always control infection risk. Staff did not always use existing control measures to protect patients, themselves and others from infection. Staff kept equipment and the premises visibly clean.

Clinical areas were mostly clean and had suitable furnishings which were clean and well-maintained. Clinical areas and furnishings were visibly clean and well-maintained. Furnishings were intact with no cracks or tears. Privacy curtains were dated and changed every three months.

Requires Improvement

Diagnostic imaging

Staff cleaned equipment after patient contact. We saw staff cleaning equipment after patient contact staff cleaning equipment following imaging procedures and where appropriate 'I am clean labels' were used. They knew what products they would use and explained how these would change depending on the clinical need.

However, in the ultrasound rooms these labels were dated for the day prior to inspection and equipment had been used that day, this meant there was a possibility it had not been cleaned after use. The policy for ultrasound equipment also specified probes should be disconnected from the unit prior to cleaning and this had not been done.

We also saw that bottles containing ultrasound gel were stored in warmers and not dated with when they had been opened. Bottles were also stored upside down in and in warmers for long periods of time when equipment was not in use. This was not in line with the current Royal College of Radiologist's (RCR) guidance and internal policy which, which stated bottles should be dated on opening. The RCR also recommends that bottles are stored upright, and the use of warmers should be limited and avoided where possible.

Staff followed infection prevention and control (IPC) principles including the use of personal protective equipment (PPE). All staff wore uniform and were bare below the elbow. However, we saw a radiographer leaving and re-entering theatres multiple times, speaking with outpatients and performing procedures without changing their surgical scrubs, this was not in line with policy that stated scrubs must not be worn outside the clinical area.

We also observed a staff member performing an aseptic procedure for intravenous cannulation on two occasions without a plastic gown, this was not in line with policy. In the area used to cannulate patients we saw a tray that contained loose items such as gauze and gloves which were open and not sterile. This was not in line with aseptic procedure IPC guidance and all items used should be sterile. The tray the items were stored in was unclean and contained dust and hair. The clinical waste bin in this area also had visible blood spots in multiple areas on the lid and side of the bin.

The department completed IPC audits in hand hygiene and environment, but these were not always consistent in the manner they were performed.

We reviewed environmental audit records supplied by the department. These indicated that environmental audits for IPC were only performed annually. The audit records for the most recent audit, performed October 2021 contained one box that was not completed, and another area recorded as non-compliant. There was no narrative given regarding action taken.

There were no audits undertaken to regularly monitor the environment to ensure correct IPC measures were being followed in clinical areas.

The department provided paper copies of hand hygiene audits; the dates indicated this audit was performed every three months. The process followed for completion of these records was unclear and the dates were not easy to interpret with multiple dates being crossed out and overwritten. Some records stated areas of hygiene compliance were not applicable, this was in contradiction to the clinical setting indicating they were. For example, four of the eight records stated observations were carried out for aseptic procedures and after bodily fluid contact, however for the statement 'Were hands wetted before applying wash product', the option not applicable was selected. This would be in contradiction to IPC guidance stating that full hand wash should be undertaken in these circumstances.

The observations on one audit was also carried out on a group of eight staff despite the sheet referring to staff in the singular form. On this form there was also an observation of staff wearing jewellery and no corresponding action documented. In addition to this only one of the eight records supplied had a compliance score documented.

All infection prevention audits were completed by a single member of staff and there was no independent checking of this information to assure it was accurate and independent. There was no evidence supplied that these audits were recorded electronically as per provider policy.

The service mostly performed well for cleanliness. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Daily cleaning was completed by housekeeping staff and clinical staff performed weekly deep cleaning in treatment rooms. We reviewed cleaning records in the digital imaging room that showed these were completed for the 4 weeks prior to inspection.

Environment and equipment

Staff were trained to use them. The design of premises and use of some facilities kept people safe. Staff mostly managed clinical waste well. However, the maintenance frequency of some equipment was not always in line with internal policy.

The design of the environment followed national guidance. The imaging rooms for digital imaging and mammography were kept closed at all times. However, the rooms containing ultrasound equipment were left open when not in use and access to these was not restricted. Illuminated signs identified when radiation was being delivered in controlled areas, this warned people not to enter. There was staff only access to the CT and MRI control areas and machines.

Waiting areas contained appropriate seating and there was music in the ground floor waiting area of the department. This removed the risk of conversations with staff and patients being overheard. However, in the CT and MRI waiting area, there were changing rooms which could be viewed from the waiting area. Patient conversations and details could be overheard by others in the waiting area. We observed a patient and radiographer in this area and conversation could be heard by other patients who were seated.

There were patient call bells in areas such as bathrooms and waiting areas, however staff told us they did not routinely test these and could not identify when this was last done. This posed a risk of call bells not working when required and a delayed response from staff.

Staff mostly disposed of clinical waste safely. In clinical areas there were separate clinical and domestic waste bins, and these were labelled.

However, in two areas we visited we saw domestic waste bins that contained clinical waste including disposable gloves and aprons. We also saw a clinical waste bin in the cannulation area that did not have a lid to contain waste.

All sharps bins we saw were closed correctly and dated. However, in the digital imaging room there were barium powder bottles disposed of within a sharps container not meant for medicines, this was not in line with waste disposal policy.

The service had enough suitable equipment to help them to safely care for patients. There was adequate imaging equipment available. There was contingency for some equipment if it was unavailable due to breakdown or maintenance. However, some equipment in the department was nearing the end of the period of recommended use. For example, the CT scanner was 13 years old, Royal College of Radiologists advise that the life span of a CT scanner is 7 years.

Requires Improvement

Diagnostic imaging

Staff in the CT and MRI control area were not aware of servicing schedules or Quality Assurance (QA) for the machines and were unable to locate them when asked. Paper records indicated this was last performed in 2015 for the CT scanner and no records could be located for the MRI scanner.

Following inspection, the service provided a copy of the past 12 month service record for the CT scanner, this showed service checks had been done more recently. However, the most recent service had been performed 5 months after the previous, this was two months later than the internal recommended interval of three monthly.

Following inspection, the department also provided an MRI cleaning and daily check sheet. The information provided showed the QA checks solely for the week of inspection, there were no records provided for before this period. The reference document provided for MRI QA that specific the checks undertaken, was also due for review in March 2021.

Other quality checks on the CT scanner had also not been performed in line with internal policy. Records showed the last air calibration been performed in December 2021 when this was required by internal policy to be done every 2 weeks, within the quality assurance plan it was stated as a weekly check. During the inspection we saw documentation of this check for January 2021-March 2022 recorded to have been performed only three times. This was inconsistent with the local policy. Following inspection, the form was amended and sent to us showing a number of other dates added.

The annual radiation protection supervisor (RPS) report for the department for 2021 had also identified that QA checks were behind schedule. This had also been discussed in the radiation protection committee in February 2022.

In addition to this within an ultrasound room, the ultrasound warmer was four months past its service date, staff were not aware of this when asked.

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 had a named radiation protection supervisor (RPS) and a named radiation protection advisor (RPA).

Staff completed risk assessments for each patient on arrival. Staff spoke with patients before undertaking a radiation exposure to ensure exposure was justified. The department used a three-point identification check with patients before undertaking an imaging procedure.

All patient risk could be recorded within the clinical booking system that all radiographers and administrative staff had access to. This would enable staff to have advanced notice of previous reactions to contrast media or contraindications to scanning such as a pacemaker for MRI.

Staff knew about and dealt with any specific risk issues. Patient referrals included areas for clinicians to detail any known risks. Patients booking MRI appointments completed MRI pre-screening risk assessments to identify and contraindications. Patients undergoing intravenous cannulation also completed assessments to identify increased levels of risk such as kidney disease or known anaphylactic reactions.

Staff were able to contact the resident medical officer (RMO) if they had any concerns regarding patients, the RMO was available 24 hours a day and seven days a week including bank holidays.

There was a 'grab bag' in the ground floor area of the department to respond to a patient emergency in this area. We saw that records for this equipment showed it had been checked on all clinical days for the three months prior to inspection.

However, staff compliance for training in basic life support was 29%. We were advised that staff in CT and MRI had training in Intensive life support, however training records provided from the department did not show compliance percentage with this training.

Staff told us that Patients who may be pregnant were asked about the possibility of this before undertaking procedures.

Staff responded promptly to any sudden deterioration in a patient's health. Staff told us how there were practice simulations for responding to patient anaphylaxis and cardiac arrest. We reviewed the report from an anaphylaxis simulation and saw that it contained detailed notes and actions for areas of learning.

However, as only one member of staff staffed the MRI scanner this posed a risk if a patient collapsed and needed to be transferred or required medical intervention. Staff mitigated the risk by working in a shared control area so that staff from the CT scanner could support them. The compliance with training in MRI Safety was 100%, however, only one member of staff for the department had undertaken this training.

The training was indicated only for appropriate staff members and it was allocated by self-selection. However, as CT and MRI control areas were shared and was also supported by HCA's, this would indicate other staff would also benefit from undertaking this training and that compliance percentage was not accurate.

In addition to this, radiation protection training was mandatory but compliance with this was 62%, the target was 95%.

Staffing

The service relied on bank and agency staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough staff to keep patients safe. Managers accurately calculated and reviewed the number radiographers and healthcare assistants needed for each shift in accordance with national guidance. Staffing was also reviewed daily at a hospital wide meeting.

The department sickness rates had reduced in the three months prior to inspection. The sickness rate for the service had decreased from 2.7% in December 2021, to 1.9% in February 2022.

The service had reducing vacancy rates. The vacancy rates from the service had reduced from 5.06% in December 2021, to 3.18% in February 2022.

The department turnover rates we around 11%, this was higher than the national average but comparable to other departments in the service.

The manager could request bank staff to support the department but we were told this required at least 48 hours' notice. Managers made sure all new bank and agency staff had a full induction and understood the service.

Diagnostic imaging

The departments use of bank staff had increased; we were told this was this was due to a number of staff moving to bank contracts instead of being on substantive contracts. In January 2022 bank staff use increased from 27 hours to 63 hours. The use of agency staff over this time period had also increased from 175 hours to 245 hours.

All staff we spoke with told us that staff shortages were their biggest concern in the department.

We were told by leaders that there was only one member of permanent staff allocated to MRI. There were also bank staff that had training in this area. We spoke with staff in MRI who told us if they were unable to work at short notice and bank staff were unavailable there were no contingencies for the patients booked for appointments. Leaders also confirmed that staff shortages would adversely impact this area and patient appointments, were they to occur.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, stored securely and easily available to all staff providing care. However not all records were up-to-date.

Records were stored securely. All appropriate staff had access to an electronic records system that they could all update. These systems were only accessible with a personal login which restricted access. Staff used radiology information systems to log scanning requests and these were then vetted by senior staff to ensure they were justified.

Patient notes were comprehensive, and all staff could access them easily. On completion of a patient procedure, all associated documents were electronically uploaded to the records system.

However, we reviewed completed 10 patient referrals and found areas were incomplete on six of 10. For example, 3 of 10 contained no imaging dose information. In addition to this there was no referrer signature on 2 documents. Two of the referrals were for patients of the age range that indicated a pregnancy check should be completed. However, neither of these records had pregnancy checks documented on them. Staff told us that pregnancy checks were also recorded on a separate document, however when asked staff were also unable to locate any additional pregnancy checks form within the records system.

Audits on record keeping had also identified areas for improvement within the department. A radiology request audit had found the in 15% of records patient information was missing, this was highlighted for discussion with the consultants who most often failed to complete this record.

Medicines

The service did not always use processes to safely administer, record and store medicines.

Radiographic staff checked blood results for patients receiving intravenous contrast to ensure this would not cause harm to body organs. Pre-assessment recording risk of anaphylaxis was also carried out a contrast check with patients on attendance before cannulation.

Staff stored contrast medicines and in line with the provider's policy. Contrast medicines were stored in cupboards in secure areas which restricted access to them.

All staff had undergone accredited training in the administration of contrast medicines.

However, when we reviewed the intravenous contrast administration policy, we found that there were two separate documents, one locally developed and one provider level, and both of these policies were past the review date. We asked staff who told us they were not aware the documents were not the most recent version.

We saw some medicines being stored and administered incorrectly. There was a locked cupboard for storing medicines, including barium powder, but this was not temperature monitored. There were also four opened and partially used containers of barium powder. Manufacturer guidance states that any unused product should be disposed of and not stored, it also recommended this product be stored below 25°c.

We observed staff preparing barium drinks for patients to drink prior to imaging. However, staff were unable to locate a process that instructed them on how to prepare this medicine and that all training had been verbal and not documented. We reviewed HCA competency records and saw that preparation of this product did not form part of HCA training.

There were also patient information sheets stored in the cupboard, but these were sealed, and we did not observe any patients being given these leaflets when contrast drinks were provided. We asked staff if they gave these sheets out and they were not aware of the need to do so. Patient information leaflets tell patients what they are ingesting and any things to look for after leaving the department in terms of side effects after the drink has been consumed.

In addition to this there was also a product stored within the locked cupboard that was labelled in French. We asked staff if they had a copy of this product information in English, but they were unable to locate one. We were told that instructions for the manner of application had been given verbally.

Incidents

Staff recognised incidents and near misses and reported them appropriately. Managers ensured that actions from patient safety alerts were implemented and monitored. However, the department did not always manage patient safety incidents well. Managers did not fully investigate incidents or share lessons learned with the whole team.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the service's policy. Staff told us they would report all incidents through the internal reporting forms, this was in line with policy.

The service had no never events.

Staff received feedback from investigation external to the service. Staff told us that organisation wide learning (OWL) alerts were sent regarding incidents elsewhere and this helped support wider learning.

Training on reporting incidents was mandatory, 64% of staff had undergone this training, the target for this was 95%.

We spoke with five staff regarding duty of candour and how it applied to their role. Four of five staff asked demonstrated a good understanding in this area. Staff told us that Duty of candour training also did not form part of mandatory training.

However, managers did not always investigate incidents in line with recommendations from the Radiation protection advisor (RPA).

Requires Improvement

Diagnostic imaging

We reviewed two incidents that were reported to the RPA. The first incident was not reportable to CQC, but the RPA recommended that a full investigation into the causes of the incident should be carried out and recorded in accordance with local clinical governance procedures. However, the incident was recorded as not requiring an RCA.

The second incident involved a patient receiving an incorrect scan due to administrative error, the RPA report for this incident was not supplied by the service but internal records stated it was not reportable to the CQC. However, as this incident involved an unintended exposure then it can be inferred that similar recommendations were likely to have been made from the RPA that a full investigation be undertaken.

There was limited evidence of learning identified for this incident. There was also no evidence to demonstrate this incident was shared more widely beyond the immediate staff involved. We reviewed staff meeting minutes and saw that staff were directed to a noticeboard to read learning outcomes. There was not however any wider discussion of incidents.

We requested information regarding the last three serious incidents reported in the service, but this information was not provided. Staff told us there were extravasation incidents and adverse reactions to contrast, we could see by reviewing staff minutes that this was reportable as an incident, so it is not clear why this was not provided. We also requested the last three RCA reports and again this was not supplied.

Are Diagnostic imaging effective?

Inspected but not rated

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. Staff protected the rights of patients subject to the Mental Health Act 1983. However, managers did not check to make sure staff followed guidance.

The service had provider policies in place to support good practice, leaders told us these were available electronically. Changes in national guidance was communicated to leaders from the provider, however there was limited evidence this was always implemented at the location.

There were no clinical audits performed to monitor compliance with policies. There were also no staff members who were identified in governance processes to be responsible for the review of CT and MRI documents. Therefore, we were not assured staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Patients attending from wards that were subject to the Mental Health Act were highlighted to staff in advance of attendance.

Nutrition and hydration

Staff gave patients drinks when needed. Staff made sure patients did not fast for too long before diagnostic procedures.

Staff made sure patients had enough to drink. There was fresh water and hot drinks were available.

Guidance was given on fasting in information given to the patient in advance. Radiographers checked this guidance had been followed when speaking with patients

Pain relief

Staff monitored patients regularly to see if they were in pain but did not use a formal scale.

Staff assessed patients' pain using verbal checks but did not use a formal scoring scale. The department did not administer any pain medicines. Inpatients attending the department would be returned to wards if their pain was not controlled so pain relief could be administered.

Patients attending from home were advised to bring any medication they needed to self-administer with them for their attendance.

However, there was no visual guide for patients who may struggle to communicate verbally.

Patient outcomes

Managers monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. However, staff were not involved in undertaking audits or improving outcomes,

The service monitored imaging discrepancy for some scan reports. There was peer review of 10% of MRI scans completed on insured patients from another provider. Peer review of MRI scans showed a discrepancy rate of less than 1%, this is better than the reported average which varies from 2.9-30%.

There was a clear image reporting pathway in place that outlined the process to be followed by radiologists on completion of reports. The pathway identified the process for inpatients, outpatients and those who had been referred by a GP. The departments had a third-party contract to support out of hours image reporting. Staff told us they had used this service and found this easy to use.

Managers carried out repeated audits to check improvement over time. The department supplied audit plan that stated there were audits in compliance with the World Health Organisation (WHO) checklist compliance, request forms, and dose levels.

The most recent WHO checklist audit had an overall compliance of 99% against a target of 100%. The audit had identified a lack of radiographer and consultant signatures on care records, this was addressed with in a monthly staff meeting.

The service did monitor dose levels for scans, and this showed them to be below the national reference levels.

Managers used the results to improve patients' outcomes. However, only leadership staff undertook these audits. This meant that there was no independent checking of data and that junior staff had little opportunity to support improving outcomes. Leaders told us that time to undertake audits was limited and that these were difficult to find the time to complete.

The service supported Cancer Research UK by undertaking scans on research patients.

However, the service did not participate in any relevant national clinical audits. The service also did not carry out any audit of practice against internal policy to monitor the quality of care delivered.

Competent staff

The service did not always make sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Most staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Radiographers, mammographers and sonographers had undertaken higher educational training to undertake their role. These staff were registered with the Health and Care Professions council (HCPC) and this registration required them to agree to a code of professional conduct to maintain registration.

Managers made sure staff attended team meetings or had access to notes when they could not attend. We reviewed the notes from the previous two staff meetings and saw they covered some updates from clinical areas. However, the areas covered in these meetings was not standardised, this meant that areas may not always be discussed, and updates provided. The content within the meeting minutes was also brief and not self-explanatory so may not provide staff with the information required from the updates.

Managers gave all new staff a full induction tailored to their role before they started work. All staff working in the department were provided with an induction checklist which gave details of a systems in the department and a wide range of other information. This contained sign off sheets for staff to become competent in the relevant areas of their role, there were checklists specific to radiographers and healthcare assistants. Staff supported newly qualified radiographers to develop their skills and there was a competency-based approach to gaining knowledge to undertake procedures.

The department had a clear list of staffing and their individual competencies and scope of work under the Ionising Radiation Medical Exposure Regulations (IR(ME)R). There was also a spreadsheet showing individual staff equipment competence. This sheet showed that 100% of permanent staff were deemed competent in the areas they were required to work in.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. In the 12 months prior to inspection, two members of staff had undertaken external learning to support them in their role.

There has been no internal departmental led radiographer education undertaken during the past 12 months. This was due to staff shortages, and COVID-19 restrictions.

Managers told us they supported staff to develop through yearly, constructive appraisals of their work. Staff we spoke with told us they felt these appraisals gave them an opportunity to identify areas for improvement. However, at the time of inspection only 45% of staff had received their annual appraisal.

In addition, there were no lead radiographers for the MRI or CT working areas although the service was currently recruiting to these areas. In MRI no permanent staff had post graduate training in this area. Lead radiographers in these clinical areas supported wider learning and service improvement. They were also responsible for updating policies and procedures to ensure the information used was the most current.

Requires Improvement

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.

Staff worked across health care disciplines and with other agencies when required to care for patients. Patients could see all the health professionals involved in their care at one-stop clinics.

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

Seven-day services

Key services were available to support timely patient care.

The service met the availability requirements for the community it served. Patients who required urgent scans could be prioritised to enable rapid diagnosis in line with national guidance.

The service offered out of hours services for patients who required urgent diagnostic services. The department was able to perform urgent CT and MRI scanning 7 days a week and at night. Staff worked on standby to provide this service.

Health promotion

Staff could direct patients toward practical support and advice to lead healthier lives on request.

The service had limited information promoting healthy lifestyles and support in patient areas. Due to infection control measure in place during our visit all leaflets in waiting areas had been removed. Staff told us they could; however, access this information on demand or direct patients towards where to find it.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff followed national guidance to gain patients' consent. However, they did not always know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. Staff training in this area was below the target set by the service.

Staff made sure patients consented to imaging based on all the information available. Staff checked with patients prior to undertaking a procedure that they understood and that the information regarding the imaging site was correct.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were able to explain clearly how they would raise any concerns with a patient's capacity to consent, to the referring clinician. They had not however needed to do this.

Staff did not clearly record consent in the patients' records. The referral document provided a space to do this, but staff told us this was not used and instead consent was gained verbally. Leaders told us the forms had been discussed with the provider as they did not feel they were fit for purpose as areas were not used. This also included a box to record previous imaging.

It was not clear how, if a patient was deemed to lack capacity to make decisions, this would be recorded within the notes. There was no formal consent policy used within the department.

Requires Improvement

Diagnostic imaging

In addition, Staff training for mental capacity was mandatory but not all staff had completed this. Training compliance for Mental Capacity Act was 57% and 64% for Deprivation of Liberty Safeguards, this was below the target of 95%.

We spoke to five staff and found that three were unclear with the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005. Staff did not always understand how the Mental Health Act applied to their own role.

Staff could also not describe their role in consent and did not demonstrate a good understanding of Deprivation of Liberty Safeguards and how this applied to their role.

Are Diagnostic imaging caring?

Good

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. During our inspection we saw staff speaking with patients and listening to them with kindness. Radiographers took time to speak with patients before and during procedures and made sure they were fully informed about what would happen.

If a patient needed additional support or attended with a carer, efforts were made to involve them in these conversations.

Administrative staff spoke with patients when they arrived and provided clear instructions to patients. They listened to patients and provided guidance on when they would receive appointments following referrals.

All staff told us how patient care and kindness was the most important thing to them in their role, it was also the thing they felt most proud of. We saw cards for staff for patients thanking them for their kindness and care.

Emotional support

Staff provided emotional support to some patients, families and carers to minimise their distress. They understood some patients' personal, cultural and religious needs. However there was no learning on supporting those with learning disabilities or living with dementia.

Staff made sure patients and those close to them understood their care and treatment. Patients were provided with details of the diagnostic procedure via email before the appointment. Staff were not aware if this information could be provided in an alternate language or easy read format.

Fees for patients who paid for their own care were available and could also be requested through the service website.

Requires Improvement

Diagnostic imaging

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We heard how some patients had been attending for many years for follow up appointments due to medical conditions. Staff were able to provide personalised care to these patients and support them.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff told us they could access interpreting services if required but these requirements would need to be known in advance if patients spoke a dialect that was not widely known.

Staff requested information on behalf of patients in formats such as large print, braille or other languages. We saw how patients were encouraged to ask questions about their procedures and were given an opportunity to do so.

However, there was no specific training on dementia or supporting patients with a learning disability. There were also no facilities or identified staff in place to support these groups of patients and improve their experience.

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. Staff were aware of some reasonable adjustments that could be made to ensure patients understood the information they were given. This included providing interpreters to support medical discussions within families.

Staff talked with patients, families and carers in a way they could understand. However staff did not have access to communication aids such as books that can be used to communicate with patients who may have difficulty understanding. These communication aids mean meant that patients could describe any symptoms and staff were able to explain procedures to them before they started.

The department did not undertake its own patient feedback, instead the department came under the hospital wide survey. Staff were not clear why they did not do their own department level feedback as other departments in the hospital had done so but thought it due to staff capacity to do so.

Are Diagnostic imaging responsive?

Good

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

Service delivery to meet the needs of the community.

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

The service provided diagnostic imaging services to the private patients undergoing both elective and urgent care. In addition to this, the department had worked collaboratively with the local NHS acute trust to share care and treatment of patients during the COVID-19 pandemic and this included diagnostic imaging procedures. This enabled the trust to continue to deliver vital services to patients whose care may have otherwise been delayed.

Requires Improvement

Diagnostic imaging

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. Doctors in outpatient clinics requested additional diagnostic imaging, such as plain film X-ray, on the same day. Plain film X-rays are the most frequently used form of medical imaging, they show up bones and certain other tissues.

We saw patients from an orthopaedic clinic coming for scans after attending appointments in the outpatient department. Patients liked that they could do this in a single visit without the need for repeated attendance.

Results were not always available during the single visit. However, they were available before the next patient attendance. Diagnostic test results were available to support timely multidisciplinary team (MDT) decisions on cancer care, treatment plans and achieve cancer waiting time standards.

Meeting people's individual needs

The Service coordinated care with other departments and providers. Staff made some reasonable adjustments to help patients access services. However the service did not take account of patients' individual needs and preferences.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff were aware of how to obtain interpreters and told us they had used them. When patients were referred, staff were given details of the preferred language spoken if this was not English for interpreters to be arranged.

The department did not have printed information leaflets available in any languages other than English, but we were told they could source these if requested from the provider website.

However, posters were not standardised in waiting areas and contained a range of fonts and colours. All posters providing guidance in waiting areas were solely in English. The sign advising patients or the risks of being pregnant during an examination was also not in an alternate language. There was also no signage related to requesting a chaperone.

There were no supportive services in place for patients with learning disabilities, autism or dementia.

Access and flow

People could access the department when they needed it and received the right procedure promptly. Waiting times for image reporting were in line with internal provider targets.

All staff we spoke with told us they thought the department was the busiest it had ever been. At the time of inspection the department was receiving around 400 referrals per week. In the previous three months there had been over 4500 diagnostic procedures performed.

Managers monitored waiting times and made sure patients could access services when needed and received image reporting within agreed timeframes and national targets. Staff told us the current waiting time for MRI was around 3 weeks, whereas for CT this was 2 weeks. This had increased as pre pandemic these waiting times were around one week.

Requires Improvement

Diagnostic imaging

We spoke with a patient who told us they had to phone several times to book an appointment as their referral had not been processed. They felt that this added to the stress of the wait for a diagnosis. Patients could not phone the department directly. However, other patients we spoke with felt their appointments were booked quickly and had experienced no problems.

The department's internal reporting target was 7 days. The department achieved this for 98.9% of scans. Within this, data showed that 83.9% of scans were reported in under 2 days. This was better than the national average.

Managers worked to keep the number of cancelled appointments to a minimum. Administrative staff told us when booking appointments, they would always confirm this verbally. This reduced non-attendance as the booking had been agreed in conjunction with the patient's availability and preference.

Managers ensured that patients who did not attend appointments were contacted. Administrative staff called all patients who did not attend to ensure they were well and ascertain the reason. They then rebooked the appointment.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with told us they would be comfortable following the complaints process, one patient we spoke with had previously complained to the service and felt that it was dealt with well.

The department clearly displayed information about how to raise a concern in patient areas. We saw leaflets in waiting areas that explained the complaints process. Patients could also request this information via the provider website.

Staff understood the policy on complaints and knew how to handle them. Staff told us they would direct all complaints to the department manager.

Managers investigated complaints and identified themes. We reviewed the four most recent complaints; these had been investigated as per policy and themes had been identified.

Managers shared feedback from complaints with staff. However, there was limited evidence to show how learning was shared with staff on a wider basis. In the most recent departmental meetings, there was no record of discussion surrounding complaints or their outcome.

Are Diagnostic imaging well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Requires Improvement

Diagnostic imaging

Leadership

Leaders had the skills to run the department, but staff shortages impacted their ability. They were visible and approachable in the department for patients and staff. They supported staff but there was limited opportunity to take on more senior roles. Key leadership roles were vacant and staff shortages meant leaders were not always available when needed.

The department was led by a manager who oversaw the entire clinical area. There was no deputy manager in post at the time of inspection, this post was not being recruited to at the time of inspection.

The manager of the department was unable to fully support staff due to staff shortages. This meant they were often working clinically and opportunities for improvement were limited.

Key clinical areas lacked overall leadership, and this meant staff were not always aware of the relevant protocols and policies for the area.

Staff spoke positively of managers and felt they were 'doing the best that they could' and that they supported them.

For our detailed findings on Leadership please see the Well led section in the surgery report.

Vision and Strategy

The service vision was limited and had not been developed fully.

The senior leadership team for the hospital had recently undergone a period of change, this meant they were in the process of developing their vision and strategy which was still in its infancy.

Although there was a clear vision, values and strategy within the executive team. This had not yet had a chance to filter down to the department and staff were not yet aware of the vision.

Managers produced a plan to embed the vision and strategy within the department, however this was still in its early stages of development at the time of inspection.

For our detailed findings on Vision and Strategy please see the Well led section in the surgery report.

Culture

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

Staff spoke positively of the department, they told us it was a good place to work and they felt valued. We saw staff engaging positively with each other and there was a clear sense of teamwork. All staff we spoke with were enthusiastic about giving good patient care.

There was a provider led policy on bullying and harassment, but staff told us they not had to use this.

The service had a provider led whistleblowing policy. However, mandatory training in whistleblowing was below target with only 64% of staff having completed this.

Requires Improvement

Diagnostic imaging

The service had a provider led Equality and Diversity policy. However, mandatory training in this topic was below target with only 64% of staff having completed it.

For our detailed findings on Culture please see the Well led section in the surgery report.

Governance

Staff at all levels were clear about their roles. Staff had regular opportunities to meet. However, leaders did not operate effective governance processes, throughout the department. Discussion at team meetings and notes from them were limited, there was limited opportunity to learn and participate in performance monitoring of the department.

Staff were aware of their roles and responsibilities. There were monthly departmental meetings, however the notes from these meetings were limited and there was no set agenda.

In the interventional radiology area, all policies and procedures were current and reflected the most recent version from the provider.

However, the policy for extravasation were not the most current version. There were also two separate policies for the administration of contrast, one provider led, and one locally developed. Staff were not clear which document was the correct version. This policy had been updated in April 2021 however the policies within the folder were dated March 2018. The list staff signed to show they had read the procedure had also not been signed by a member of staff who performed intravenous cannulation and contrast administration on a daily basis.

In three scanning rooms there were copies of the local rules that were not the most current version, this was also restricted to three pages of a 35 page document. Staff were asked and unable to locate an electronic version.

For clinical procedures such as CT and MRI scanning protocols staff followed department level policies. However, in multiple areas we visited paper copies of documents were not the most recent versions. For example, in the MRI control area, Staff were unable to locate any written protocols for the scanner. When asked, inspectors were shown an external website not monitored by the location. This website did not have any dates on policies. Following our inspection, we were told that all policies for the scanner were in a folder in the control area.

The protocol folder for the CT scanners contained protocols that were past their review date. All clinical scanning protocols were dated for review in March 2021. Staff were unaware of this. In addition, the corporate “Ionising radiations protection policy” in the folder was past the review date of October 2021, staff were unable to locate the most recent version. When asked who the staff member who was responsible for the development of CT policies, staff told us this member of staff had recently left the service and this role was being recruited to. In MRI there was no identified lead for policies as substantive staff was limited to one member of staff.

There was also evidence of limited governance process to ratify documents, this included emails to consultants to review multiple document changes with limited discussion before giving approval.

A central corporate team was responsible was responsible for ensuring corporate policies and procedures were kept up to date.

For our additional findings on Governance please see the Well led section in the surgery report.

Requires Improvement

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 some unexpected events. However, in MRI there was little contingency in place for staff shortage.

The department had several radiation protection supervisors in place. Controlled radiation area signs gave contact names and contact details for the radiation protection supervisor. A Radiation Protection Supervisor is appointed for the purpose of securing compliance with the Ionising Radiations Regulations 2017 for work carried out in an area which is subject to Local Rules.

There was a corporate lead for radiation protection but there was limited evidence of how the department was monitored routinely. Department leaders shared twice yearly information that was shared at the radiation protection committee.

Radiation protection committee meetings were attended at corporate level only, Radiation protection supervisors and deputies did not attend these meetings. Staff in the department were not aware of the outcome of these meetings and the issues discussed. This was a missed opportunity for wider learning as CQC reportable radiation incidents were discussed at them. Staff told us they did receive emails informing them of events elsewhere, but this method limited discussion.

The department had a risk register in place. This identified the main risks for the department.

For our additional findings on Management of risk, issues and performance please see the Well led section in the surgery report.

Information Management

The department collected some data and analysed it. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service ensured data or notifications were sent to external bodies as and when required. Policies and procedures were stored primarily in paper format and some paper copies were out of date. Leaders told us all documents were stored electronically, however, staff we spoke with were unable to demonstrate they knew how to access them.

For our additional findings on Information Management please see the Well led section in the surgery report.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

The department did not collect their own patient feedback, this limited opportunities for staff to improve services and gain insight into improvement.

The service engaged with patients within a whole hospital feedback survey which sought feedback to improve the quality of the services provided. Patient feedback was displayed and share with the team and used to improve the service.

For our detailed findings on Engagement please see the Well led section in the surgery report.

Requires Improvement

Diagnostic imaging

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services, however, opportunities for this were limited.

Staff in the department were committed to learning and improving patient experience. However, due to staff shortages opportunities for this were limited. There was also an absence of leaders in key clinical areas that could be used to drive improvement, learning and innovation.

No staff in the department were trained in quality improvement or developing project to improve services.

For our detailed findings on Learning, continuous improvement and innovation please see the Well led section in the surgery report.

Good

Outpatients

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

Are Outpatients safe?

Good

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

Mandatory training

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

Staff received mandatory training but did not always keep up to date with this. The most recent training figures showed that staff completed on average 90% of their modules. This was an improvement on the figures seen during the inspection in 22 March 2022.

However, evidence given following the inspection showed some modules remained below the provider target level including immediate life support, infection control (practical) and manual handling (practical).

Managers told us some staff had not completed all their mandatory training due to sickness and parental leave.

The mandatory training was comprehensive and met the needs of patients and staff. Staff completed mandatory training on subjects to support them in their roles including infection prevention and control, COVID 19, the Mental Capacity Act, health and safety and medical gas modules.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers assessed an electronic system which monitored staff completion rates of mandatory training.

Managers could see the mandatory training status for each staff member and the status of each individual module. Managers individually reminded staff to complete upcoming mandatory training.

Safeguarding

Good

Outpatients

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 completed level two in safeguarding for adult and children. The most recent figures showed 92% of eligible staff had completed their adult safeguarding training and 92% of eligible staff had completed child safeguarding training. A safeguarding lead for the department supported staff.

Managers could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Managers gave an example of a child suffering from Female Genital Manipulation (FGM) and the actions they took to protect the patient including alerting the local authority. Managers placed advertising material for patients offering support for domestic violence in the toilet cubicles of the department.

Staff could recognise adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff had a clear understanding of how to recognise and report abuse. Staff could access contact details of the local safeguarding teams and the hospital's safeguarding policy.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had up to date policies for safeguarding children and vulnerable adults. Staff could explain how to raise a safeguarding incident using the department's incident reporting system. Staff knew what actions they would take if they had concerns. The department had made one safeguarding referral in the last 12 months.

Cleanliness, infection control and hygiene

The service mostly 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 well-maintained, but some furnishings did not meet infection control standards. All areas in the outpatient's department were visibly clean. The waiting areas and clinic rooms had chairs made with a wipeable material to promote effective cleaning. However, consultation rooms were part carpeted and the department did not have a local risk assessment for this. This is not in line with national guidance which states should carpet be used in consulting rooms; it is essential that a documented local risk assessment is carried out. Managers said that patients were screened before attending their appointment and if there were infection concerns, a patient would only be seen in the examination area of the room. Records showed cleaning was completed everyday apart from days the department was not open.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Managers audited cleaning checklists completed by staff in the department. Deep cleaning of the department occurred once a month and records supported this.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff had access to PPE including; aprons, masks and gloves in a variety of sizes. Staff were seen following guidelines around the safe application and removal of PPE. Managers challenged staff who wore PPE incorrectly when this occurred.

All staff were 'bare below the elbows' which enabled effective hand washing and all staff cleaned their hands before, during and after patient care in line with the World Health Organisation guidance on the "five moments for hand hygiene". We saw posters reminding staff of these five moments.

Consultation rooms within the outpatient department had posters to show the maximum occupancy of each room to enable social distancing.

Staff completed IPC training and the manager was the nominated infection prevention and control (IPC) link for the department. The IPC link held, responsibility for the oversight of IPC processes. Managers could raise concerns about the outcomes of IPC audits with senior hospital staff. However, staff completion rates for IPC training were below the provider target.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff used a sticker system which showed when a piece of equipment had been cleaned and was ready for use.

Environment and equipment

The design, maintenance and use of facilities and premises kept people safe. However, equipment arrangements for resuscitation were not safe. Staff were trained to use equipment correctly. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. Emergency alarms were fitted in all consulting rooms and the system was tested during our inspection. Staff responded promptly when this occurred.

The design of the environment followed national guidance. The department was one corridor with the surgical outpatients and endoscopy units attached. A cardiology outpatient unit was in a separate section of the hospital. The department was on one floor and divided into colour coded sections which aligned to different specialities. Separate examination rooms for gynaecology, dermatology, ear, nose and throat (ENT) and eye clinics were provided. The minor procedures room had a dedicated scrub sink and PPE station for staff

Receptionists were available to process and welcome patients upon entry to the department Receptionists screened patients for COVID-19 symptoms verbally and complementary face masks and hand sanitising gel were available for patients arriving. The waiting area was in partial sight of the reception desk with chairs socially distanced and a TV operating advertising material for the provider. The waiting room had a water machine available for patients. A coffee machine was out of use due to COVID-19 restrictions.

Managers completed health and safety risk assessments for the building and staff. Managers completed the last assessment in February 2022 for the department which did not find any concerns that needed action.

Staff carried out daily safety checks of specialist equipment. Managers ensured specialist equipment was covered under a service level agreement to cover both maintenance and call out visits when they were needed.

Staff checked the resuscitation trolley for adults and children in the department and ensured it was in working order and stock was available. Staff completed stock checklists for the trolley on a daily and weekly basis. The trolley had defibrillator pads for adults and children that were in date. Staff had access to a paediatric anaphylaxis box and items were in date. Staff used anti-tampering devices on the trolley to ensure it was not assessed by unauthorised persons.

However, the location of the resuscitation trolley was at one end of the outpatient department corridor. This was away from where minor operations occurred. Staff expressed that if an emergency occurred in the minor operations room or consulting rooms on the opposite side of the corridor, staff would need to get the trolley and move it through a

potentially busy corridor to bring it back to the incident. Managers we spoke with confirmed this. This was not in line with national guidance. The Resus Council UK quality standard states; “All clinical service providers must ensure that their staff have immediate access to appropriate resuscitation equipment and drugs to facilitate rapid resuscitation of the patient in cardiorespiratory arrest.”

The service had enough suitable equipment to help them to safely care for patients. Managers organised an external company to complete electrical safety checks for all equipment in the department yearly. Staff felt they had enough suitable equipment to carry out their role. Staff stored stock in a suitable manner. Staff stored consumables neatly in trolleys, consulting and treatment rooms. Consumables in the outpatient department were in date and there was evidence of stock rotation.

Staff disposed of clinical waste safely after each clinic. Staff labelled sharps bins correctly and did not overfill them. Staff emptied waste bins after each clinic and stored it securely in a dirty utility room until collection by cleaning staff. An external company then collected waste. Clinical waste bins were secure in an outside storage area of the hospital.

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. However, some arrangements for resuscitation needed improving.

Staff responded promptly to any sudden deterioration in a patient’s health. All staff knew how to identify and manage deteriorating patients. Alarms were in each consultation room. Staff knew what actions to take and who to escalate their concerns to. Staff had training in immediate life support which included basic life support training to ensure they had the skills to help a deteriorating patient. However, the completion rate for Immediate life support was below the provider target. Staff had access to a resident medical officer (RMO) on site to respond to any sudden deterioration episode.

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

Booking staff completed risk assessments for each patient before their arrival at the department. Staff knew in advance which patients were attending the department. Patients needing extra help were identified during the booking of their appointment. This included mobility, sight and hearing requirements. Reception staff were able to monitor patients in the waiting room. Patients felt comfortable and knew they could approach reception if they needed help.

Staff shared key information to keep patients safe when handing over their care to others. Staff had policies and procedures for the safe admission of patients to the hospital if this was assessed as required. Staff assisted consultants in the processing of referrals to other services in the hospital such as physiotherapy.

Shift changes and handovers included all necessary key information to keep patients safe. Staff completed handovers between shifts and discussed arrangements for patients ahead of their appointment where needed.

Staffing

Good

Outpatients

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

The service had enough nursing and support staff to keep patients safe. Managers felt they had enough staff to keep patients safe. Managers arranged rotas for the department in advance. Staff were positive about how the department was staffed and there was enough staff with the right skill mix to cover clinics so that consultants and patients had suitable members of staff during clinics. Managers attended daily safety huddles at the hospital each morning to report staffing numbers and any difficulties they were experiencing. Managers shared staff with other departments to ensure that patient care wasn't interrupted.

The service had low vacancy rates for staff. The department had a 3.9% rate in February 2022.

Sickness rates for staff were low. The department had a 0% rate in February 2022.

The service had a 10.8% turnover rate for staff in February 2022.

The manager could adjust staffing levels daily according to the needs of patients. Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift based on the type and number of clinics running and the number of patients attending. Managers had rotas that looked at the staffing needs of the department.

Managers limited their use of bank staff and requested staff familiar with the service. Managers had one nurse and two technicians on their bank staff list. Managers expressed that the department avoided using agency staff.

Managers made sure all bank staff had a full induction and understood the service. Managers had used bank staff in the past year. Managers completed the same induction checklist relevant to the department as full-time staff. This included making staff aware of any department specific information. We saw a copy of the induction programme to confirm this.

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

Records

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

Patient notes were comprehensive, and all staff could access them easily. Consultants fully completed patient records and included details such as clinical assessments, risk assessments, medicine, allergies, and consent. Staff fully completed WHO surgical checklists for minor operations.

Good

Outpatients

There were no delays in staff accessing patient records when they were required. Staff oversaw the transfer of records from the medical records department to the outpatient department where staff placed them in the nurse's office. Staff leading the running of the clinic would collect the records and return them following the clinic. Staff locked this office when there weren't staff present. All records were paper based, but managers were keen to explore electronic alternatives in the future.

Records were stored securely. Staff stored patient notes in a separate locked area to the clinical area. Staff working in the department had access to patients' records for the clinics running that day but could request for records to be brought to the department for ad-hoc appointments.

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. Consultants prescribed medicines during clinics. Consultants had a paper-based prescription system when they needed to do this.

Staff stored and managed all medicines and prescribing documents safely. Pharmacy arrangements ensured the safe storage of medicines. Managers tracked and safely stored blank prescriptions. The department had dedicated pharmacy staff responsible for medicines. Pharmacy staff reviewed medicines to check they were in date and there was evidence of stock rotation and monitoring. The processing of any controlled drug prescriptions occurred away from the department. Pharmacy staff checked medicines that required fridge storage remotely using electronic systems. Staff checked emergency medicines once a week and completed daily and weekly checklists. All emergency medicines had security tags to prevent tampering. Staff stored medical gases including oxygen and liquid nitrogen correctly. The hospital had an oxygen pipeline system in areas where staff completed minor clinical procedures.

Staff completed medicines records accurately and kept them up-to-date. Staff kept a record of any medicine prescribed which was put in the patient's notes.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents but did not have formal department processes to share lessons learned with the whole team. When things went wrong, the hospital and department had processes that gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff had access to an incident reporting system. Staff showed an understanding of incidents or events that would require reporting. Managers used a clear policy and pathway to guide staff on how to report incidents.

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

Staff reported 57 incidents and near misses in the past 12 months. Managers categorised incidents to indicate harm that resulted from the event.

The department had no never events in the past 12 months.

Good

Outpatients

The department had no serious incidents in the past 12 months.

Managers and Staff understood the duty of candour, but they could not give examples as no incidents had met the criteria for this. Managers demonstrated an open and honest approach with patients, apologising if something went wrong and learning lessons through the process.

Managers investigated incidents thoroughly. A separate team in the hospital initially reviewed all incidents reported by the department. Managers were contacted by the complaints team when needed to provide information. Managers were responsible for showing actions and learning lessons as part of a wider hospital process. Please see the surgery core report for more details.

Although managers provided feedback individually to staff who reported an incident, incidents and lessons learned were not a standard agenda item at the department meetings. This meant learning from incidents was not shared amongst the team to make sure that action was taken to improve safety. Managers advised us that incidents were recorded and discussed at a different meeting and that the information was fed back to staff, but we did not see evidence of this.

Are Outpatients effective?

Inspected but not rated

At present we do not rate effective for outpatient departments in acute independent hospitals.

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. Clinical staff and leaders discussed new guidance during monthly clinical governance meetings and at the medical advisory committee. Managers received new information relevant to the department to review and implement.

Managers used policies related to outpatient care including; safeguarding vulnerable adults, complaints, mental capacity, and infection control. These were up to date with consideration of national guidance from the Nursing and Midwifery Council, the Office of the Public Guardian, and the National Institute for Health and Care Excellence.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff were trained in the Mental Health Act and showed awareness associated with patients who were identified as needing support during the booking process at the hospital. This included consent considerations such as best interest decisions and the Derivation of Liberties process. Staff of the department had 100% completion for mental capacity act and deprivation of liberties modules as part of their mandatory training. However, no examples were available where this knowledge had been implemented in the department.

Please see the surgery core report for more details

Good

Outpatients

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Consultants and staff routinely assessed for pain when it was clinically indicated and during and after minor operations. Consultants discussed pain if it was a risk in the presenting condition and recorded this in the patient notes.

Patients received pain relief soon after requesting it. Consultants managed pain relief while running their clinic. Managers and staff could access pain medication through the pharmacy at the hospital.

Please see the surgery core report for more details

Patient outcomes

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

There were no national audits relevant to this outpatient department.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used an electronic system which monitored patient outcomes at the hospital, however data for the outpatient department performance was limited.

Please see the surgery core report for more details

Competent staff

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

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. The hospital took responsibility for checking the professional registrations of its staff and managers were aware of this process. Healthcare assistants had completed an external care certificate or held an equivalent qualification for their role.

Managers gave all staff a full induction tailored to their role before they started work. Staff were given a mentor to support them when they first joined the team. Managers had line manager responsibility to several new staff members who had started a preceptorship with the hospital and those we spoke with expressed how welcoming and helpful the team had been.

Managers supported staff to develop through yearly, constructive appraisals of their work. Managers discussed staff development during appraisals and included extending staff responsibilities to support development, for example a staff member had developed from a non-clinical role to a clinical role through conversations and appraisals with managers.

Good

Outpatients

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Managers and staff said that face to face department meetings occurred monthly. Staff who were unable to attend accessed the most recent meeting minutes in the department office.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers did yearly appraisals with staff and there were meetings for staff to discuss their development needs. Staff gave positive feedback regarding their development and felt supported.

Managers made sure staff received any specialist training for their role. Managers arranged for more training where needed. For example, training on wound management. Staff had opportunities to assist in specific areas of care including dermatology. A mole mapping clinic was being developed for launch in 2023 and staff training was discussed in supporting this venture.

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 and managers held regular and effective multidisciplinary meetings to discuss patients and improve their care. Managers from the outpatient department met daily with managers from other departments for a safety huddle so that achievements and pressures could be discussed. This information was shared with staff following the huddle.

Wider multi-disciplinary team (MDT) working in the department involved regular meetings with the cardiology outpatient department, however formal minutes of these meetings were not completed. More widely, the department had arrangements with the local NHS Trust and supported them through dedicated oncology clinics which focused on breast and urology cancers. Staff were seen working well together. They described a positive working environment where they felt respected and were able to raise concerns with their colleagues and managers if they needed to.

Patients could see all the health professionals involved in their care at one-stop clinics. The department interacted with other departments to optimise patient care. For example, managers consulted with diagnostic imaging so that patients could have their scans on the same day as their appointment.

Please see the surgery core report for more details

Seven-day services

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

The provider operated clinics six days a week. Consultants ran their clinics at different times in the morning, afternoon and evening on weekdays. Outpatient clinics did not run on Sundays but were operational on Saturday morning and afternoon.

Health promotion

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

Good

Outpatients

The service had relevant information promoting healthy lifestyles and support in patient areas. The department had relevant information available for promoting healthy lifestyles and support in clinics. Managers removed information leaflets from the department in line with COVID-19 guidance. The information was available if requested by patients and followed the accessible information standards.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Consultants and staff discussed consent for surgical procedures during appointments. Staff gave patients time to have a discussion with their consultant and time to think about their treatment options. Consent was documented in all five of the patients records we reviewed from consultations. Patients had a cooling off period of two weeks before any elective cosmetic surgery was carried out.

Staff clearly recorded consent in the patients' records. Staff gained written consent for minor operations such as skin procedures including mole removal surgery. We reviewed five records which showed staff fully completed this. Staff and managers had arrangements to support the communication needs of patients when giving their consent. For example, translation services and braille alternatives. Staff could arrange this with the medical secretary ahead of the appointment time.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff completion rates for this training was 100% for the department.

Staff could describe and knew how to access the policy on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff could explain where policies were found for reference if they needed this. Staff did not have examples associated with complex consent, but the hospital had policies available on the hospital intranet which took into account national standards and legislation.

Are Outpatients caring?

Good

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

Compassionate care

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

Good

Outpatients

Staff were discreet and responsive when caring for patients. Clinic and treatment rooms had signs on the doors to show if the room was vacant or occupied. We saw staff using these signs when taking patients into rooms. Staff knocked and waited before entering closed doors. Reception staff were discreet when talking with patients to prevent their conversations being overheard by other patients.

Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff assisted patients when needed including the provision of mobility aids. Staff gave examples of how they gave reassurance to patients having a minor operation. This included the use of humour, holding a patient's hand and planning for a relative to be available for them as soon as possible following their procedure.

Patients said staff treated them well and with kindness. Patients gave positive feedback about the service. Comments Included:

"I have had excellent care during my visits. My operation has been completed to a very high standard".

"Staff are very friendly and very helpful in explaining the processes involved in my care. I have never felt rushed".

"All very positive. Staff are very caring".

We spoke with 10 patients during our visit to the department and all feedback was positive about the staff and care they received.

Managers displayed patient feedback in the nurse's office and several examples of positive praise were given to the team verbally from patients using the service. Prior to COVID-19, the department had a friends and family survey that used feedback cards; however, this was currently on hold.

Staff followed policy to keep patient care and treatment confidential. Staff closed doors during consultations and ensured privacy was kept throughout the patient visit to the department. Patients and their families could give feedback on the service and their treatment. When needed, staff supported them to do this. Managers told us that they directed patients to their web site as a way for them to provide feedback.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff cared for patients and were attentive to their needs during interactions. For example, we saw staff opening doors and providing help for patients.

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

Good

Outpatients

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 were aware of the impact on relatives to patients and made efforts to keep them informed if their relative was undergoing a procedure.

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 provided examples of how they helped patients as part of their role. Several examples of feedback we reviewed praised staff on their engagement with patients during an appointment and their clear manner in explaining decisions for treatment. Staff were attentive and explained processes to their patients. For example, where a procedure was proposed, staff were praised as being clear, kind and considerate to patient needs. Patients described feeling empowered to make their own choices and that there was flexibility associated with this.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff knew the needs of patients in advance of their appointment. This included the arrangements for the support of patients that required translation services, sight, hearing, and mobility support. The hospital had a consultant who specialised in bariatric care and support was available in the department to empower these patients.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Managers promoted patient feedback through their web site and staff were proactive in directing patients to this.

Staff supported patients to make informed decisions about their care. Staff had training to help them support patients during consultations including those that required support due to cognition concerns.

Patients gave positive feedback about the service. We spoke with 10 patients who all provided positive feedback about the way staff cared for them.

Are Outpatients responsive?

Good

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

Service delivery to meet the needs of local people

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. However, the department needed further oversight measures when appointments were cancelled.

Good

Outpatients

Facilities and premises were appropriate for the services being delivered. The department was designed appropriately, and it supported social distancing where possible. Signs were used to aid patients in navigating the department. Toilets were available in individual rooms by the main reception with suitable locks for privacy. The hospital had car parking facilities for all services.

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. Managers and staff co-ordinated with other departments to ensure that patients were able to have all their tests during one visit. For example, diagnostic scans were scheduled on the same day as an appointment and this was organised through consultant's medical secretaries to enable this.

Managers could not monitor or take action to minimise missed appointments. Managers had no oversight measures for the triaging of patients when they missed an appointment. Staff did not contact patients that did not attend their appointment. Instead, medical secretaries could rebook patients into the next available clinic, but this process had to be started by the patient. This meant that staff missed opportunities to identify safeguarding issues, incorrect addresses, telephone numbers and maintain an ongoing oversight of patient safety.

However, patients could contact medical secretaries to rebook their appointments if they cancelled before their appointment and patients could also seek support following an appointment. For example, in a post-operative situation, patients could receive a prompt appointment to support them.

Meeting people's individual needs

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

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff knew in advance which patients were attending clinics that day. Staff highlighted patients on the clinic list that required extra help or support and measures were organised to support them.

The service had information leaflets available in languages spoken by the patients and local community. Staff had access to information leaflets in a variety of font sizes, braille and alternative languages. The information leaflets were not on display in line with Covid 19 guidance, but staff offered information leaflets as part of their role. Patients we spoke with confirmed this.

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

Staff had access to communication aids to help patients become partners in their care and treatment. Managers had suitable arrangements and signs to let patients know hearing loops were available in the hospital. Staff provided patients with information on the facilities provided at the hospital. The information met the accessible information standard.

Good

Outpatients

Staff used patient information to provide care and treatment in a safe way and eliminate risks. If staff felt the service could not meet the patient's needs, staff referred them to an alternative health care provider who could better support the patient.

Managers wanted to enhance their support for patients living with dementia. Managers explained following the inspection, that they want to introduce a full-time dementia champion to the department.

Access and flow

People could access the service when they needed it and received the right care promptly. However, the department did not have suitable oversight measures for patients if they needed support.

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

There wasn't a waiting list for appointments in the department. Medical secretaries were responsible for booking appointments when they were received, and this was normally within two weeks of receiving the request. If an appointment was cancelled or a patient was unable to attend, medical secretaries would be responsible for the rebooking of the appointment. This was managed between the secretaries and the department using an electronic booking system which displayed the available clinics in the department.

A separate booking team at the hospital handled elective skin procedures.

Managers worked to keep the number of cancelled appointments and treatments to a minimum. Managers could add and remove clinics when demand required them to do this. Managers used a shared electronic booking system with consultants' medical secretaries when making bookings on behalf of patients.

Learning from complaints and concerns

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

Patients and relatives knew how to complain or raise concerns. Patients we spoke with knew how to make a complaint and the process they would follow.

The department received two complaints in the last 12 months.

Staff understood the policy on complaints and knew how to handle them. Staff and managers knew how to manage complaints and made efforts to resolve them. Managers expressed that they would make efforts to resolve the concern as soon as possible.

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

Good

Outpatients

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Complaints reviewed showed outcomes and learning from the process were shared with patients. There was a policy and process for this. However, there were no recent examples in the department to review.

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

Are Outpatients well-led?

Good

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

Leadership

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

There were clear lines of leadership and accountability. The manager had clinical responsibility and managed the registered nurses and healthcare assistants. The cardiology outpatients service was managed by a separate manager who worked closely with the department and there were clear communication processes with the pharmacy team.

Managers had a good understanding of the challenges to quality and sustainability in the department and were able to tell us the actions needed to address them. They felt supported by other members of the senior management team. They were able to discuss any issues with them, were listened to and their views respected.

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

The department had a management structure with clear lines of responsibility and accountability which staff understood. The head of the outpatient department had responsibility for the running of the clinics and took part in the wider governance and meeting structure of the hospital. This meant they understood the priorities of the hospital and how their department was involved in delivering this. Staff understood their job role and their responsibilities. Staff could name who their line manager was and who to speak to for specific situations such as safeguarding.

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

Please see the Surgery core service report for wider details of the hospital leadership.

Vision and Strategy

Good

Outpatients

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.

Managers had a vision and strategy for the department which ran from 2020 to 2023. Managers divided the strategy into domains that followed the Care Quality Commission's key question framework. Managers had colour coded a chart to show progress and this included evidence of success in achieving progress towards its aims. The strategy was displayed in the nurse's office of the department for staff to view so that they could understand the direction of the department. However, changes in the hospital at leadership level had meant that some aspects of the strategy were under review to correlate with the changing priorities of the hospital.

Please see surgery core service for wider details of the hospital vision and strategy.

Culture

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

Managers promoted equality and diversity. There was a display board showing the team photographs and flags of staff nationality. Staff spoke of a friendly, inclusive environment which included international nurses from different cultures who had recently started in the department. Ninety three percent of staff had completed equality and diversity training.

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

Please see surgery core service for wider details.

Governance

Leaders 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.

Managers had monthly meetings to give information to staff face to face. Staff had access to meeting minutes in the nurse's office. Staff held responsibility for certain areas of the department, and this was clearly displayed in the nurse's office for reference.

From the several meeting minutes we reviewed, there was evidence that managers discussed, shared, and acted upon information. Information included recruitment, health and safety, medicine management, complaints and leadership updates. We noted that incidents were not a standardised agenda item. Managers advised us that incidents were recorded and discussed at a different meeting and that the information was fed back to staff, but we did not see evidence of this.

Staff could raise operational concerns both at meetings and privately with their line manager who would then escalate this to suitable governance meetings at the hospital.

Please see surgery core service for wider details of the hospital governance processes.

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 department had a risk register which managers reviewed regularly. The main risks were the need to review social distancing arrangements during busy periods, air conditioning maintenance needs, and infection prevention and control risks.

Managers entered risks into an electronic system where risks were reviewed by hospital leaders on an ongoing basis using a meeting structure. Managers performed audits that focused on the IPC performance of the department and health and safety audits were completed. Staff had awareness of these risks and there were arrangements for managers to update staff during department meetings on how risks were checked and the actions they needed to take if required.

Managers had arrangements to cope with unexpected events. For example, the sharing of staff with other departments was a frequent theme we heard from managers to ensure that patient care wasn't interrupted.

Please see surgery core service for wider details on the hospital approach to risk.

Information Management

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

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

Staff received mandatory training for information governance and the completion rate was 100% Staff were mindful of confidential information held by the department and took steps to ensure this information was secure. Confidential waste bins were available in the department and used by staff. Staff kept confidential documents such as patient notes secure and locked when they were not in use. Porters had a responsibility to dispose of confidential waste in a suitable manner. Managers and staff reported any breaches of information governance as incidents on their electronic system.

Please see surgery core service for wider details.

Engagement

Good

Outpatients

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

The department actively encouraged patients to give feedback about their experience to help improve services. For example, the department focused on web site feedback and this was reviewed by the leadership team before being shared with managers of the department and staff during their meetings.

Managers understood the importance of staff feedback. The outpatient staff were happy in their roles and felt listened to. A staff forum was in operation to enhance staff morale and opinion.

Please see surgery core service for wider details.

Learning, continuous improvement and innovation

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

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

The department was active in suggesting improvements in department processes. Managers and staff had suggested moving towards more sterile one-use equipment and have also been active in wanting the department to move away from paper-based systems towards more electronic systems. The suggestions had not been implemented at the time of our inspection.

The introduction of new clinics has also been explored. A new dermatology mole mapping clinic is currently in development and is being proposed to launch in 2023.

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service must ensure that the correct personal protective equipment is used when undertaking aseptic procedures and the clinical area used for venepuncture is maintained in line with infection control policy. Regulation 12 (1)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service must ensure the governance and quality assurance for the department is effective; including for all clinical procedures, servicing of equipment, learning from incidents and the use of current policies and procedures. Regulation 17 (1)