Ramsay Health Care UK Operations Limited

Buckshaw Hospital

Inspection report

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

Ratings

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

Summary of findings

Overall summary

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

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Leaders monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. They provided emotional support to patients, families and carers. Feedback from patients was positive.
- 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.
- Experienced and compassionate leaders ran services effectively 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 and took pride in their work. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However

- Not all staff had received an appraisal in the last 12 months.
- Records of employment checks were disorganised. At the time of our inspection the service was not able to demonstrate full compliance with the requirements of Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Records of temperature checks for medications were not always completed.
- Departmental meetings were not always completed regularly and did not always follow the standing agenda.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care (Including older people's care)	Inspected but not rated	We inspected but did not rate this core service. • The endoscopy service performed well for cleanliness. The design of the environment followed national guidance. The department had suitable facilities to meet the needs of patients. • Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. Staff monitored the effectiveness of care and treatment. Staff supported patients to make informed decisions about their care and treatment. • 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. • Experienced and compassionate leaders ran services effectively 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 and took pride in their work. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually. The service only provided endoscopy under the medical care core service and therefore is a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery report.
Surgery	Good	This was the first inspection of this core service. We rated it as good because:

Summary of findings

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Leaders monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. They provided emotional support to patients, families and carers. Feedback from patients was positive.
- 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.
- Experienced and compassionate leaders ran services effectively 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 and took pride in their work. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

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Summary of findings

service was not able to demonstrate full compliance with the requirements of Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Diagnostic imaging

Good

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

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

Summary of findings

However,

- Staff did not always adhere to best practice for disinfecting probes and temperature recordings for all medications were not always completed.
- The local rules for radiation needed updating to ensure the main contacts were included, the department should have information visible for patients regarding key staff for the department.
- Personal development reviews were not always completed in a timely manner and
- Departmental meetings were not completed regularly and did not always adhere to the standard agenda.

Summary of findings

Contents

Summary of this inspection

Background to Buckshaw Hospital

Buckshaw Hospital opened in October 2021 and is 1 of 33 centres across the UK where Ramsey Health Care UK Operations Limited is working in partnership with the NHS.

The hospital provides services for adults over the age of 18 years only. Children were not seen at this service.

We have not previously inspected this service.

Buckshaw Hospital has day surgery facilities including 2 theatres, single patient pods with sliding doors, outpatient/ pre-assessment rooms and a treatment room. The day unit is developed for the assessment, diagnosis and treatment of conditions on a day case basis for both NHS and private patients locally.

Buckshaw Hospital adds the following additional facilities to those which are already in place at another Ramsay hospital (3 miles away) with:

- 2 theatres 8 recovery pods.
- 4 admission pods.
- 6 outpatient consulting rooms.
- 1 treatment room.
- Appropriate waiting area – admissions lounge.
- Free onsite parking.

Surgical procedures included ambulatory and day surgery only, gastroenterology, general surgery (including laparoscopic inguinal hernia repair and breast surgery), orthopaedics, gynaecology, urology and ear, nose and throat procedures.

In the 12 months prior to our inspection, 5,822 surgical procedures had been carried out at Buckshaw Hospital.

Buckshaw Hospital offers flexible appointments to patients choosing to attend the service for a private diagnostic or NHS funded scan and had the following facilities for diagnostic imaging:

• Waiting area specifically for the department

• 2 scanning rooms

• 2 control rooms

• A cannulation area

• A recovery room

• A counselling room

• Patient changing areas with lockers

Summary of this inspection

• Patient toilets

• A plant room

• Mammography room

The diagnostic imaging department offered patients Magnetic Resonance Imaging (MRI) scans, Computed Tomography (CT) scans, Ultrasound scans and 3D Mammography scans.

In the 12 months prior to our inspection, 10,997 scans had been carried out at Buckshaw Hospital.

How we carried out this inspection

As this was the first inspection of this hospital, we inspected 3 core services: surgery, diagnostic imaging and medical care. Many of the systems and processes within the service were hospital wide. The surgery report is the main report for this inspection and therefore where any findings are the same for all core services, these will be included in the surgery report only.

The team that inspected the service comprised of 2 CQC Inspectors and 2 Specialist Advisors with expertise in theatres and diagnostic imaging.

The team inspecting surgery spoke with 11 staff, 4 patients, and reviewed the records and associated documents for 4 patients.

The team inspecting diagnostic imaging and medical care spoke with 9 staff, 4 patients and reviewed the records and associated documents for 8 patients.

We also met with members of the hospital's leadership team.

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

Areas for improvement

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

Action the service SHOULD take to improve:

Surgery

- The service should ensure all staff receive a regular appraisal to review their performance and provide support to identify training and development needs. (Regulation 18)

Summary of this inspection

- The service should consider reviewing the arrangements for records of employment checks in line with the requirements of Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Diagnostic Imaging

- The service should ensure that they record the serial number of the probes when disinfecting them, in line with best practice guidance. (Regulation 12)
- The service should ensure that the names of the Radiation Protection Supervisors (RPS) and the Radiation Protection Advisor are clear for patients to see when they are in the department. (Regulation 12)
- The service should ensure that all consumables are stored away appropriately. (Regulation 12)
- The service should ensure temperature recordings are completed for all medications that require it. (Regulation 12)
- The service should ensure all copies of the local rules throughout the diagnostic imaging department have been updated to include the new Radiation Protection Advisor contact details. (Regulation 17)
- The diagnostic imaging service should ensure departmental meetings are completed and the standard agenda is used, as in other departments within the hospital. (Regulation 17)
- The service should ensure that all staff working on the diagnostic imaging department have a good understanding of the effects of electromagnetic fields on their personal health and should consider offering training to them. (Regulation 18)
- The service should ensure yearly personal development reviews are being completed in a timely manner. (Regulation 18)
- The service should consider having the 'five moments for hand hygiene' advice above the sinks in the department which will act as a reminder to staff and patients of how to clean their hands correctly.
- The provider should consider completing radiology reporting audits for scans completed for both private and NHS patients.
- The service should consider having information leaflets available in different languages for patients from diverse and ethnic backgrounds.

Our findings

Overview of ratings

Our ratings for this location are:

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

Inspected but not rated

Medical care (Including older people's care)

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

Is the service safe?

Inspected but not rated

We did not rate safe. We found:

Mandatory training

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

See surgery report for further information.

Safeguarding

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

See surgery report for further information.

Cleanliness, infection control and hygiene

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

The endoscopy service performed well for cleanliness. We saw evidence that theatre cleans took place immediately after the completion of endoscopies.

See surgery report for further information.

Environment and equipment

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

The design of the environment followed national guidance. The endoscopy area had a dirty utility area for the manual cleaning and disinfection of endoscopes.

Inspected but not rated

Medical care (Including older people's care)

The department had suitable facilities to meet the needs of patients. The theatre in which endoscopy procedures were completed had appropriate ventilation.

Staff had enough suitable equipment to help them to safely care for patients and themselves. Staff had quick access to the resuscitation trolley which was checked daily and weekly.

The service had safety tested all electrical equipment.

See surgery report for further information.

Assessing and responding to patient risk

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

A surgical safety checklist was completed with patients undergoing endoscopies. This provided details of safety checks completed at the start of the endoscopy procedure and before any of the team left the endoscopy room.

See surgery report for further information.

Staffing

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

The endoscopy service was on the same roster as the theatre staff, please see the surgery report or further information.

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.

Please see the surgery report or further information.

Medicines

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

The service had standard operating procedures for medical gases such as Nitrous Oxide and carbon dioxide used in endoscopy.

Please see the surgery report or further information.

Incidents

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

Endoscopy reported 10 clinical incidents in the last 12 months.

Inspected but not rated

Medical care (Including older people's care)

Please see the surgery report for further information.

Is the service effective?

Inspected but not rated

We did not rate effective. We found:

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.

Please see surgery report for further information.

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.

Please see surgery report for further information.

Pain relief

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

Staff carrying out endoscopy procedures checked levels of pain pre, during and after the treatment. The National Early Warning Score (NEWS) was used to monitor a patient's condition.

Please see surgery report for further information.

Patient outcomes

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

The endoscopy service was not Joint Advisory Group on gastrointestinal endoscopy (JAG) accredited. The hospital needed to have delivered the endoscopy service for 12 months before being able to apply for JAG accreditation. Recent JAG audits of the service have resulted in the service planning to apply for JAG accreditation in the next 3 months.

Private endoscopy patients from 1 May 2022 and 30 April 2023 scored 100% for having a good experience of the hospital, whilst 99-100% of NHS patients did.

The service also inputted to the national Private Healthcare Information Network (PHIN) to improve patient outcomes. We saw evidence of how the service had analysed the data from endoscopy patients experience of the hospital and had identified the key themes that would need to be addressed.

Please see surgery report for further information.

Inspected but not rated

Medical care (Including older people's care)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. However, appraisals were not always completed in a timely way.

Please see surgery report for further information.

Multidisciplinary working

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

Please see surgery report for further information.

Seven-day services

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

Please see surgery report for further information.

Health promotion

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

Please see surgery report for further information.

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 obtained consent for the endoscopy procedure at the pre assessment stage, and this was checked on admission as part of the World Healthcare Organisation (WHO) checklist.

Please see surgery report for further information.

Is the service caring?

Inspected but not rated

We did not rate caring. We found:

Compassionate care

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

Please see surgery report for further information.

Inspected but not rated

Medical care (Including older people's care)

Emotional support

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

Please see surgery report for further information.

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. Feedback from patients was positive.

Please see surgery report for further information.

Is the service responsive?

Inspected but not rated

We did not rate responsive. We found:

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.

Please see surgery report for further information.

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.

Please see surgery report for further information.

Access and flow

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

Please see surgery report for further information.

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.

Please see surgery report for further information.

Inspected but not rated

Medical care (Including older people's care)

Is the service well-led?

Inspected but not rated

We did not rate responsive. We found:

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.

Please see surgery report for further information.

Vision and Strategy

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

Please see surgery report for further information.

Culture

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

Please see surgery report for further information.

Governance

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

Please see surgery report for further information.

Management of risk, issues and performance

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

Please see surgery report for further information.

Information Management

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

Inspected but not rated

Medical care (Including older people's care)

Please see surgery report for further information.

Engagement

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

Please see surgery report for further information.

Learning, continuous improvement and innovation

Leaders encouraged innovation and improvement. All staff were committed to continually learning and improving services. However, staff did not receive training in quality improvement.

Please see surgery report for further information.

Good

Surgery

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

Is the service safe?

Good

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

Mandatory training

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

The mandatory training programme was comprehensive and met the needs of patients and staff. A training matrix was available on the provider intranet which outlined the mandatory training requirements for all staff groups. The target for training compliance was 95% for all modules. Staff were required to complete to 25 modules, dependent on their role. Of the 25 modules, 12 had a compliance rate of 100%. Only 3 modules had a compliance rate slightly below 95%.

Leaders told us training compliance was currently impacted by long term staff sickness and maternity leave. In addition, the service had recently employed new staff who were working through the mandatory training at the time of our inspection. Any staff who were non-compliant had been provided with a scheduled date to complete outstanding modules.

Bank staff were also included in mandatory training compliance figures. They were required to complete the same mandatory training as substantive staff.

The service used an electronic system to record and monitor mandatory training compliance. The system automatically sent alerts to staff when training was due to be completed. The hospital training lead pulled off reports each month to monitor compliance at site, department and individual level. These compliance rates were shared with heads of departments and senior leaders.

All clinical staff had attended face to face training in Safeguarding Adults and Children Level 3.

Mandatory training for doctors was not included within these figures. Doctors working on practicing privileges were required to provide annual evidence of mandatory training completed. The application and approval documents for clinicians working under practicing privileges were comprehensive and outlined the mandatory training requirements. Leaders held a register of clinicians working under practicing privileges and completed an annual audit to be assured of compliance.

Good

Surgery

Each month the hospital was closed for one day for staff training. Staff were given time to complete mandatory training and additional face to face training was also provided. Leaders said these additional training topics were driven by incident themes and patient or staff feedback. We saw additional 'speak up for safety' and autism and dementia training had recently been delivered face to face.

New staff had an induction period of 6 weeks and staff were required to complete competencies according to their role. Leaders checked compliance with competency requirements at regular one to one meetings with staff.

Mandatory training compliance was discussed at monthly integrated governance meetings with actions identified to improve compliance.

Safeguarding

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

All staff (including bank staff) received training specific for their role on how to recognise and report abuse.

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

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

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They demonstrated an effective awareness of the hospital's safeguarding processes. The hospital had 2 named safeguarding leads who had completed level 4 training and were available for support and advice.

Safeguarding Adults and Children policies were available for staff to follow to report any safeguarding concerns to the hospital's safeguarding lead, as well as giving relevant contact phone numbers for local authority safeguarding teams.

CQC received no notifications of alleged abuse about this service in the 12 months prior to our inspection in April 2023.

Staff were required to demonstrate competence and understanding as part of their induction before they could act as a chaperone. Posters were on display throughout the hospital explaining how patients could access a chaperone.

Safeguarding information was available on the provider website which could be accessed by patients and members of the public. This included information about the safeguarding arrangements and relevant national guidelines and regulations.

The head of clinical services was responsible for completing an annual audit of safeguarding to ensure that local processes were followed.

In the 12 months prior to our inspection, 9 appropriate safeguarding referrals were made by staff at the hospital.

We reviewed 8 staff employment files. At the time of our inspection, we did not see evidence that all required recruitment checks, including Disclosure and Barring Service checks had been completed as the storage of these documents was disorganised. Following our inspection, the service provided evidence that all required checks had been completed.

Good

Surgery

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.

All areas were visibly very clean and had suitable furnishings which were clean and well-maintained.

Appropriate systems and processes were in place to ensure the cleanliness of the hospital was maintained. Legionella and pseudomonas safety and testing programmes were in place.

Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. Checklists had been completed according to the hospital's policy.

Suitable posters were visible across the hospital, regarding IPC precautions. Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Staff used disposable curtains in recovery areas and changed them every 6 months or if soiled.

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

The hospital had reported no healthcare associate infections (HCAIs) since it opened in 2021.

The audit schedule included a suite of infection prevention and control audits that were completed throughout the year. The audits included in the schedule were:

- IPC governance and assurance
- IPC environment
- Sharps
- PPE
- Isolation arrangements
- Hand hygiene
- Management of linen
- Cleaning
- Peripheral venous cannula care bundle
- Urinary Catheterisation bundle
- Surgical site infections

The results of department cleaning audits, known as '49 steps', completed in April 2023 were:

- Outpatients 100%
- Physiotherapy 96%
- Theatres 100%

The results of hand hygiene audits completed in April 2023 were:

- Day case ward 100%
- Outpatients 100%
- Pharmacy 100%
- Theatres 100%

The service scored 100% compliance in the PPE audit completed in April 2023.

The hospital scored 95% in a hospital wide IPC governance and assurance inspection report in March 2023. There was one area of non-compliance which was because the IPC link nurse did not have protected hours to fulfil their role.

The service scored 100% on the patient led assessment of the care environment (PLACE) for cleanliness and the condition, appearance, and maintenance of the hospital in 2022.

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

The hospital had an Infection Prevention and Control policy which outlined the processes for staff to follow. Systems were in place to monitor healthcare-associated infections and other infections including resistant organisms; and ensure the results were shared across the organisation and used to drive continuous quality improvement.

Local and regional infection prevention group meetings took place each month. We reviewed meeting minutes from both local and regional meetings. The meetings were well attended, had standard agendas which included relevant topics such as performance data, audit outcomes and national guidelines. We saw evidence of effective discussions taking place and actions being identified and followed up at subsequent meetings. The regional meeting group had nominated a regional representative who would attend the provider corporate IPC committee to escalate any concerns.

Patients were provided with information leaflets before and after surgery to explain the steps they could take to reduce the risk of surgical site infections. These leaflets included pre-operative decolonisation and post-operative wound care advice.

Environment and equipment

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

The design of the environment followed national guidance. The hospital theatre operational policy included safe environmental working parameters such as air change rates and temperatures. The policy also referenced relevant Health Building Notes (HBN) and Health Technical Memorandums (HTM). Air change rates in the theatres and treatment room were compliant with national requirements.

The hospital provided day case procedures only. There were no inpatient beds. There were 2 theatres with adjoining anaesthetic room, preparation area and scrub area. The theatre environment was visibly clean and tidy. All equipment was situated on suitable racking provided. The theatre and anaesthetic rooms were cleaned, and equipment stocked daily. Documentation was completed daily.

Each clinical area of the hospital was secured by locked doors which could be accessed by swipe card only. We observed staff escorting patients around the hospital.

Good

Surgery

Staff carried out daily safety checks of specialist equipment, including resuscitation equipment. No gaps in daily and weekly checks records were noted on equipment we reviewed. All equipment was fit for use. Clinical sterile supplies were provided by an external company.

We saw records that demonstrated staff received regular training to use specialist medical equipment.

Servicing contracts were in place with third party contractors to maintain and calibrate all medical equipment. Leaders held a servicing log which included all medical equipment. We reviewed this log and saw all equipment was in date for servicing except 2 items which were scheduled to be serviced shortly after our inspection.

Staff performed monthly checks of the expiry dates of consumable items. We saw these checks were always completed and that all consumable items we checked during our inspection were in date.

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

Staff disposed of clinical waste safely. Appropriate facilities were in place for storage and disposal of household and clinical waste. Appropriate segregation of household and clinical waste took place with secure storage areas viewed outside the back of the hospital. Sharps disposal bins were available in all relevant areas. They were dated and the temporary closure mechanism was in use. There had been no reported needlestick injuries in the last 12 months.

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

A detailed fire risk assessment was in place valid until September 2023. The service followed the provider's detailed fire manual, which had a review date of June 2025. Firefighting equipment seen was fit for purpose.

All Control of Substance Hazardous to Health (COSHH) chemicals were stored securely and appropriately in locked cupboards with restricted access.

Cleaning equipment was colour coded in line with National Patient Safety Agency recommendations. Colour coding of hospital cleaning materials and equipment ensured these items were not used in multiple areas, therefore reducing the risk of cross-infection. Housekeeping staff adhered to the colour coded mop and bucket system to avoid cross-contamination.

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

Maintenance staff attended the morning huddle. We saw that any concerns addressed were managed and resolved quickly and that plans were in place to reduce the impact from any planned maintenance work.

Processes were in place to monitor the temperature of the blood bank fridge and an automated alert system was in place in the event of any temperature breaches. A contract was in place with a third-party contractor for maintenance and calibration of the blood bank fridge.

Good

Surgery

The hospital ran a PLACE audit in 2022. The audit looked at the cleanliness and maintenance of the environment, privacy and dignity, and how suitable the environment was for patients with dementia or a disability. The hospital scored over 95% in all areas. Some small areas for improvement were identified and we saw leaders had taken action to make relevant changes.

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.

Pre-operative assessments included all relevant risk assessments. Pre-operative tests and screening were completed in accordance with national guidance. The hospital had a 'patient journey' policy and a pre-operative assessment pathway standard operating procedure which outlined the steps required at each stage of the patient journey including pre-operative assessments. The hospital also had a separate policy for MRSA screening.

Staff knew about and dealt with any specific risk issues including sepsis, venous thromboembolism risks, falls and pressure ulcers. We reviewed patient records and saw comprehensive risk assessments were carried out at pre-assessment consultations with each patient, and these were regularly reviewed and updated as and when required. The electronic system in use gave a complete audit trail for each patient throughout their period of care and treatment at the hospital.

The service could access mental health liaison and specialist mental health support for patients when needed. This would be escalated to the hospital's residential medical officer as and when required.

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

Staff used the National Early Warning Score 2 (NEWS2) to identify deteriorating patients in accordance with the National Institute for Health and Care Excellence (NICE) Clinical Guidance. We saw a 'Track and Trigger' recognition of unwell patients on the wall in the patient recovery area which guided staff on how to score and asked staff about actions they had taken where NEWS was greater than 1. The chart provided clear guidance on NEWS and staff knew how to use this.

The hospital audit schedule included audits every 3 months of NEWS2 and VTE completion. No concerns were identified.

Staff demonstrated a good understanding of sepsis recognition and treatment. Staff followed the provider's 'Recognition and Management of the Deteriorating Patient' clinical policy which included national recognition tools to assist in identifying a deteriorating patient/resident and to enable them to take appropriate action. Staff said they also had regular awareness sessions.

Staff received life support training at a level suitable for their role.

The service had introduced a blood storage fridge on site and had a service level agreement with the local blood bank. This was to facilitate blood availability to patients who required transfusion prior to being transferred to an acute trust.

The hospital utilised the World Health Organisation (WHO) Surgical Safety checklist. We observed completion of the checklist during our inspection. All theatre staff involved in patient care were present and involved. All patients were

discussed individually, including their procedure; allergies; patient name, and the order of the list was also discussed. All staff were engaged in each stage and spoke up when questions were asked. We viewed the debrief in theatre. All disposables were counted by 2 members of the theatre team pre and post op as per regulations and documented on the board provided. All instruments were also checked. The swab checks were competed appropriately. We saw examples of staff raising concerns in safety briefings to maintain the safety of staff and people who use the service.

The hospital had a policy for non-critical transfer of patients from Buckshaw Hospital to another nearby Ramsay hospital, with overnight facilities. This policy outlined the procedures that staff should follow for patients from Buckshaw Hospital who did not meet the discharge criteria and needed an in-patient stay due to non-critical medical reasons.

The hospital was a member of the Lancashire and South Cumbria Critical Care Network. Staff could access the network guidance for emergency critical care transfers from independent to NHS care. The guidance included clear flow charts and contact details to support staff if patients needed emergency transfer to NHS critical care services.

We saw posters on display throughout the hospital with the contact details for the NHS ambulance service healthcare professional line. Staff could access this service to arrange transport for patients who needed emergency or urgent transport between hospital sites.

We saw an example of a patient with post operative complications being identified quickly by clinicians and the patient being returned to theatre and then transferred to another hospital for monitoring overnight. We were told that in month prior to our inspection, 2 patients had been transferred out to NHS services. Both patients experienced surgical complications and full investigations were completed which determined that safe care and treatment had been provided.

Regular scenarios were held of emergency situations such as major haemorrhage or anaphylaxis. The provider requirement was for these scenarios to be held 6 times per year, but the hospital leaders has decided to do this monthly to maintain staff competence. We reviewed records of 2 scenarios which had been held in theatres and outpatients in the last 6 months. Records of the learning event were comprehensive and included some minor learning points. The records showed staff had acted quickly and appropriately in emergency situations.

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

The service had enough staff to keep patients safe. Staffing levels met patients' needs on the day of the inspection.

Leaders accurately calculated and reviewed the number and grade of staff needed for each shift in accordance with national guidance. The Association for Perioperative Practice (AfPP) guidelines were used to determine theatre levels in theatre. This was included in the hospital theatre operational policy. Leaders used the National Institute for Health and Care Excellence (NICE) safer staffing tool to determine nurse staffing levels in all other clinical areas.

The service used a electronic rostering system. Shifts could not be allocated to nurses unless they had provided evidence of an up-to-date professional registration, and this has been logged on the system. Rostering was completed 4 to 6 weeks in advance to allow for robust staff management and planning, ensuring substantive and bank staff were available to enhance safety and offer continuity. Leaders could adjust staffing levels daily according to the needs of patients.

Good

Surgery

We reviewed the staff rosters for the month of April 2023 and found all shifts to be staffed in accordance with national guidelines. Bank staff and staff from the provider's nearby location, were utilised to ensure safety was always maintained in the event of any staff absence due to sickness, annual leave or training.

The target staff sickness rate for Buckshaw Hospital was less than 3.5%. The sickness rate between March 2022 and March 2023 was 5.8%. Leaders told us sickness rates had been higher than expected in the last 12 months due to some long-term sickness and compliance with national COVID recommendations.

The staff turnover rate between March 2022 and March 2023 was 22.5%. The hospital opened in October 2021 with an entirely new staff group. Leaders said turnover rates were higher than expected but this was mainly due to the day case environment not meeting the expectations of some staff who started when the hospital opened. At the time of our inspection, clinical teams were well established, and most staff reported being happy in their roles.

At the time of our inspection, leaders reported 3 vacancies in theatre staffing (Operating department practitioner or scrub nurses). We saw these roles were advertised on the provider website.

An open recruitment day was planned for 9May 2023.

The service had a staff bank which was utilised across the three local sites. Leaders told us how bank staff tended to work at one of the sites, so they became familiar with the environment and processes.

Patient care and procedures were consultant led. Consultants were appointed under a practicing privileges basis and the surgical lists were planned in accordance with their availability. The service had enough medical staff to keep patients safe. Resident Medical Officers (RMOs) at Buckshaw Hospital worked 8am to 8pm. All RMOs had ALS training.

All senior leaders took turns being on the on-call rota and could be contacted when required for advice and support. Leaders could access locums when they needed additional medical staff. Leaders made sure locums had a full induction to the service before they started work.

Records

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

Patient notes were very comprehensive, and all staff could access them very easily. The hospital used the provider's electronic patient record system for most aspects of the service provided from pre-assessment, through to contemporaneous notes of care interventions and treatment provided. Leaders described the records system as 'paper light' rather than 'paper free'. They spoke of the plan to move completely to electronic records but wanted to ensure this was done safely rather than quickly.

We reviewed 4 patients records and saw that all required records and assessments had been completed.

Staff confidently navigated the electronic system to demonstrate the various risk assessments and documents. The electronic system was easy to navigate.

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

Records were stored securely. All computers were left locked when not in use.

Good

Surgery

Medical records audits were included on the hospital audit schedule and were completed every 6 months. The most recent records audit was completed in April 2023. The overall compliance rate was 74%. However, the audit template was designed for inpatient facilities and therefore some of the criteria was not relevant for Buckshaw Hospital. The template the provider supplied did not allow the auditor to mark sections as not applicable. All relevant sections of the audit scored 100% compliance. Audit outcomes and associated actions were discussed at departmental meetings.

The hospital followed the providers clinical record keeping policy which outlined staff responsibilities and the standards that were expected to meet legal and regulatory requirements.

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. The hospital medicines optimisation policy was comprehensive and included guidance for staff to follow on medicine storage, destruction, prescribing and administration.

Medicines' management meetings took place quarterly and reported into the hospital's quality governance meeting. Medicines management meetings were led by the hospital pharmacy team and attended by the Controlled Drug Accountable Officer (CDAO) and a nominated link from each department in the hospital. In addition, the Pharmacist attend the Medical Advisory Committee (MAC) so any concerns could be escalated and discussed.

At the time of our inspection, the provider was recruiting for a full-time pharmacist to be based at Buckshaw Hospital. A pharmacist from one of the providers other locations was providing cover in the interim supported by the Pharmacy Technician at Buckshaw Hospital. Despite working across several locations, the pharmacist demonstrated they maintained good oversight of medicines safety at Buckshaw. The pharmacy stock management system was running effectively. Staff spoke highly of the support they received from the pharmacy team.

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

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. We saw theatre staff checked the dates on all medicines prior to use. Staff completed medicines records accurately and kept them up to date.

Staff stored and managed all medicines and prescribing documents safely. Appropriate, secure storage facilities were in place. Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

The pharmacy team attended the morning huddles which took place each day. We saw medicine related concerns were highlighted, discussed and appropriate action was taken.

Safety alerts were distributed centrally by the provider. Leaders were required to act on these and record what action, if any, was taken. We saw safety alerts were also discussed in morning huddles.

The pharmacist delivered face to face medicines management training for all clinical staff. They had introduced a knowledge test as part of this training to ensure staff had the skills and competence to safely manage medicines.

The hospital pharmacy team had a suite of audits on the hospital audit schedule. They completed 6 monthly 'safe and secure' audits of medicine storage in each department within the hospital, 6 monthly prescribing audits, 6 monthly medicines reconciliation audits, 3 monthly controlled drug audits and annual audit of pharmacy governance. We reviewed 6 of these audits. Overall audit outcomes were positive. In areas of non-compliance, action plans had been formed and the hospital pharmacist followed up the actions to ensure they were completed.

A monthly audit of antimicrobial prescribing had been introduced in March 2023. Ten patient records were reviewed to assess if treatment was provided in accordance with the local antimicrobial prescribing policy. In March 2023, 100% compliance was achieved. In April 2023, 70% compliance was achieved. Clinicians had been given feedback by the auditor and it was highlighted that in some of the non-compliance cases, clinicians had deviated from the local policy due to patient sensitivities. The audit was due to be completed again in May 2023.

In the 12 months prior to our inspection, there had been 10 medication related incidents. There were 5 reactions to medication, 3 medication errors, 1 patient overdose and 1 relating to expired stock. All the incidents were reported and investigated. None of the incidents were graded as serious or major.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Leaders 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. Leaders ensured that actions from patient safety alerts were implemented and monitored.

All incidents were reported using an electronic database. All reported incidents were discussed at the hospital's governance meetings and appropriate actions taken.

In the 12 months prior to our inspection there had been 207 incidents reported on the incident reporting system; 35 of these incidents were clinical incidents occurring in the surgical department. Incidents were graded on considering the consequence of the incident and the likelihood of it happening again on a scale of 1(serious) to 4 (minimum). Of the 207 incidents, there were no serious (1) incidents, 2 major (2) incidents, 24 moderate (3) incidents and 181 minimum (4) incidents. The 2 major incidents were reported due to complications following surgery.

Leaders investigated incidents thoroughly. Patients and their families were involved in these investigations. Leaders debriefed and supported staff after any serious incident. Staff used the safety data to further improve services.

The hospital had an incident reporting policy which outlined the procedures and timescales for reporting and investigating incidents. The policy also outlined responsibilities for identifying and sharing learning from incidents. The policy also linked to other relevant policies such as the hospitals 'being open' policy which outlined the process for applying the duty of candour.

The service had introduced an active speaking up for safety programme which empowered all staff to report incidents without fear of victimisation.

The service had no never events. Leaders shared learning with their staff about never events that happened elsewhere.

Staff received feedback from investigation of incidents, both internal and external to the service in line with the provider's policy. Staff met to discuss the feedback and look at improvements to patient care at the daily safety huddles and at handover meetings.

Good

Surgery

The hospital followed the provider's 'Being Open' policy which aimed to improve the quality and consistency of communication when patients were involved in an incident by ensuring that, if mistakes were made, patients and/or their relative/carers receive promptly the information they need to enable them to understand what happened by following a clear process. Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. Staff were fully able to explain how duty of candour principles would be applied. A Duty of Candour log was in place to evidence compliance with the regulations and a checklist was in place to support with the process. A member of the senior leadership team completed an audit of Duty of Candour in January each year.

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

The hospital director and head of clinical services reviewed lessons learned and cascaded them through the local Medical Advisory Committee to all consultants, Clinical Governance Committee, and departmental meetings.

We reviewed 3 incident report and investigations and found the investigations were thorough and timely. Appropriate lessons had been identified and effective actions plans were in place to support improvements. Themes and actions were routinely discussed at head of department, governance, and Medical Advisory Committee meetings.

All open incidents were discussed at the morning huddle each day to track progress and share learning. Incidents and learning were also discussed in head of department meetings, governance meetings and the MAC.

Leaders and staff were able to provide examples of learning from incidents and where changes had been made to improve quality and safety.

Is the service effective?

Good

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Leaders 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. Policies seen were reflective of national guidance. We saw regular policy updates were provided centrally via the provider's central alert system. This included monthly updates on National Institute for Health and Care Excellence (NICE). These were discussed at the hospital's clinical effectiveness and audit group meetings. Staff could access policies easily.

A comprehensive audit programme was in place for 2023 covering all departments, the required frequency and deadlines for completion. As Buckshaw Hospital had only been open since October 2021 some national audits results were not yet available. The Blood Safety and Quality Regulations (BSQR) 2005 annual audit of transfusion services was scheduled for May 2023.

Good

Surgery

An audit of site marking in line with the National Safety Standards for Invasive Procedures (NatSSIPS) was completed in April 2023. Full compliance was achieved in all areas and no areas of non-compliance were identified.

An audit of the management of histology specimens in line with the NatSSIPS had been completed in April 2023. Full compliance was achieved in all areas and no areas of non-compliance were identified.

An audit of swab counting during invasive procedures in line with the NatSSIPS was completed in March 2023. Full compliance was achieved in all areas and no areas of non-compliance were identified.

An audit of handling and checking surgical instruments in line with the NatSSIPS was completed in March 2023. Full compliance was achieved in all areas and no areas of non-compliance were identified.

An audit of safety briefs in theatres in line with the NatSSIPS was completed in March 2023. Full compliance was achieved in all areas and no areas of non-compliance were identified.

Nutrition and hydration

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

The hospital provided day case services only. There were no inpatient beds. Staff made sure patients had enough to drink including those with specialist and hydration needs. Patients confirmed this. We saw patients in recovery had their hydration needs met.

The hospital had food options for patients with specialist dietary needs such as gluten free.

Staff accurately completed patients' records where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition if required. We saw that these risk assessments were reviewed regularly.

Specialist support from staff, such as dietitians and speech and language therapists, could be arranged if so required but this was unlikely to be required due to Buckshaw Hospital being a day case facility only.

Patients waiting to have surgery were not left nil by mouth for long periods. Patient feedback confirmed this.

Pain relief

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

Staff assessed patients' pain using the NEWS2 tool and gave pain relief in line with individual needs and best practice. Patients told us they received pain relief soon after requesting it. We reviewed patient records and found staff prescribed, administered and recorded pain relief accurately if required.

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

Patient outcomes

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

Good

Surgery

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

Leaders told us they were submitting monthly data to Patient Reported Outcome Measures (PROMs) however this data had not yet been published at the time of our inspection.

The NatSSIPS cover all invasive procedures including those performed outside of the operating department. The hospital audit schedule included NatSSIPS audits which looked at the safety brief, sign in/out, site marking and histology. Audits were repeated every 6 months. Audits we saw demonstrated good compliance.

All theatre staff showed good awareness of NatSSIPS. We saw frequent review of activity and outcomes discussed at the regular Heads of Department and Clinical Governance meetings. Leaders shared and made sure staff understood information from the audits. Improvements were checked and monitored.

Leaders monitored patient outcomes as part of the monthly key performance indicators.

In the 12 months prior to our inspection:

- 3 patients had been returned to theatre due to post operative complications.
- 4 patients had been transferred to other healthcare facilities for further care and treatment.
- 1 patient had experienced a fall.
- No patients had been diagnosed with deep vein thrombosis (DVT) or venous thromboembolism (VTE).
- There had been no post operative infections.
- No inter or post operative haemorrhages.
- 2 post operative haematomas
- 1 readmission

Competent staff

The service made sure staff were competent for their roles. Leaders appraised staff's work performance and held supervision meetings with them to provide support and development. However, appraisals were not always completed in a timely way.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Leaders gave all new staff a full induction tailored to their role before they started work. Staff all said they had received both corporate and local inductions, which had met their needs.

All staff were required to complete a list of competencies tailored to their role. Competencies had to be achieved before staff could work independently and these were reviewed annually. A matrix was available which outlined which competencies were required for each role. The competency documents included pre-operative assessment, safeguarding and medicines optimisation competencies.

Leaders identified poor staff performance promptly and supported staff to improve. Staff and leaders had access to 2 policies from the provider, a 'performance improvement policy' and a 'performance development review policy'. Senior staff followed these policies to support the learning and development needs of staff.

Good

Surgery

Leaders made sure staff attended team meetings or had access to full notes when they could not attend. Leaders identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Leaders made sure staff received any specialist training for their role.

The hospital followed the provider's procedures for ensuring all consultants had appropriate practising privileges arrangements, including medical indemnity cover. A practising privilege is the 'license' agreed between individual medical practitioners and private healthcare providers and governs the range of surgery they are competent to perform. The provider's 'Facility Rules' took effect from September 2019 and applied to all hospitals and clinical facilities operated by the provider. These 'Facility Rules' set out a minimum level of standards and requirements necessary to achieve the best outcomes for consultants, patients and the provider.

We saw a well-defined local process was in place for applications for practising privileges. To maintain accreditation with the hospital, healthcare professionals applying for practising privileges were required to provide evidence at the point of application, but also every year, to support ongoing oversight of their practice. This included evidence of professional registration, mandatory training, medical indemnity cover and appraisals. The process worked well and in the last 12 months, 8 consultants had not been granted practicing privileges as they had not met the requirements outlined in the provider policy.

We saw 12 out of 69 consultants' appraisals were overdue. Leaders told us this was due to appraisals being postponed nationally during the COVID-19 pandemic. All out of date appraisals had a scheduled date for their next appraisal.

The head of clinical services completed audits of practicing privileges in January, July and October each year.

Leaders explained bank staff were treated as permanent staff, and they were required to complete the same training and competency requirements.

The provider policy required staff to have a structured personal development review (PDR) every year. In addition to this, leaders told us how they held regular informal meetings with staff to support wellbeing. The provider target for PDR compliance was 95%. We saw that compliance rates with PDRs in each department was:

- Theatres 100%
- Day ward 86%
- Outpatients 90%
- Physiotherapy 92%
- Non-clinical staff 74%

The numbers of staff in each department were low which meant overall compliance was heavily impacted by each out of date PDR. Overall, 8 members of staff were overdue a PDR. There was also 5 new staff members who were working through their induction and therefore were not included in PDR compliance figures.

We saw that some staff had received additional training to perform extended lead roles in some areas for example mental health first aiders, an infection control lead, a resuscitation lead and COSHH leads.

Multidisciplinary working

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

Good

Surgery

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Each morning, a "Hospital Huddle" with all senior and department leaders was held to discuss the resuscitation team for the day; any staffing issues; any concerns; the activity for the day; any safeguarding issues; finance and any open complaints or incidents. A record of this meeting was then shared with all staff by email so that information about who to contact if they had any concerns was available. We observed this huddle whilst on site and reviewed a week of huddle records. The huddles were attended by relevant departmental representatives and played a vital part in the daily running of the hospital and keeping people safe.

Every morning there was also a theatre department huddle with the whole team to discuss the theatre lists and any issues from previous day; theatre lists and cases for the current day; resuscitation team arrangements; key issues from the main hospital huddle and then everybody was asked if they have any other issues or positives to highlight.

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

Staff and leaders worked clinically and operationally in collaboration with staff from other nearby locations owned by the provider to provide good care to patients. We were told that most of the consultants also worked at the other nearby location owned by the provider.

Seven-day services

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

Buckshaw Hospital provided a day case service, 6 days a week. The service was closed on a Sunday. Working hours, including Saturday, were flexed to meet demand. There were no inpatient beds.

A medical officer was always onsite throughout the working day. Patients were reviewed by consultants as part of their care pathway. Patients could access support from doctors and other services, including diagnostic tests, 24 hours a day, 7 days a week at other local facilities if so required.

Health promotion

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

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

A variety of patient information leaflets were available for the procedures that were performed at the hospital. These leaflets included information to support them to recover well including advice about wound care, returning to work and the importance of a healthy balanced diet. The leaflets also included information about who to contact if patients had any concerns or became unwell.

Consent and Mental Capacity Act

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

Good

Surgery

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance. Records reviewed and staff and patient feedback confirmed this. If patients could not give consent, staff were aware of how to make decisions in their best interest, considering patients' wishes. At handover and huddle meetings, staff referred to the psychological and emotional needs of patients, their relatives and carers when required.

The hospital exclusion criteria meant that patients with a psychiatric history or severe mental health condition would not be suitable to receive care at Buckshaw Hospital. These patients would be referred on to another suitable service.

The hospital had a policy for obtaining consent. The policy outlined the principles of obtaining consent in a two-stage process and the role and responsibilities of staff. Four consent forms were available dependant on the age and mental capacity of the patient and the type of procedure. The consent form for patients who lacked capacity included guidance for staff about the process which should be followed. The form included guidance on capacity assessments, best interest, the use of an independent mental capacity advocate (IMCA) and lasting power of attorney.

Staff made sure patients consented to treatment based on all the information available and this was an integral part of the pre-assessment consultation. Staff clearly recorded consent in the patients' records. There was a thorough audit trail in the electronic patient records we viewed. Consent was taken in clinic at least two weeks prior to admission then the patient was re-consented on day of surgery as per requirements. Patients we spoke with told us they were provided with enough information to make informed decisions about their care and treatment.

All health care professionals who performed invasive procedures or completed the two-stage consent process received training in informed consent in line with the hospital consent policy.

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

An audit of consent had been completed in March 2023. The overall compliance score was 96%. The auditor found that not all records included documentation of COVID-19 risks being discussed with patients. In addition, not all records included documentation of what information had been provided to patients to confirm that the patient had given informed consent. This audit was scheduled to be repeated to measure for improvement.

Is the service caring?

Good

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

Compassionate care

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

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

Good

Surgery

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

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

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff knew the needs of each individual patient very well and provided a person-centred approach to the care they delivered.

The hospitals used an electronic system to capture real time patient feedback using several patient experience survey systems. The combined data for the hospitals in March 2023 showed they performed well but were slightly lower than the provider's national average.

- 'Respect and dignity' feedback, 96.3%, slightly lower than the provider's average of 97.5%.
- Private Healthcare Information Network (PHIN) patient experience, 93.4% of patients who gave feedback said their overall experience of this hospital was good or very good.
- Hospital Friends and Family Test, 100% for NHS patients,96% for private patients.
- Net Promoter score (which measures customer experience), 85, slightly lower than the provider's average of 86.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff told us who they would support patients and we saw positive examples during the inspection. Staff were very empathetic and caring.

Staff provided appropriate care to those patients that were in communal areas, such as the reception area, in line with their needs assessed needs and care planning. Staff demonstrated empathy on all care interactions we saw.

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 used a holistic, person-centred approach to each individual patient, and took time to get to know them and their needs and wishes. We saw examples of staff working with patients and relatives who were anxious to make reasonable adjustments and ensure their needs were met.

The hospital had a quiet room which could be used to meet the needs of patients. For example, this room could be used by patients who wished to pray in line with their beliefs, or for patients who needed some time alone.

Understanding and involvement of patients and those close to them

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

Good

Surgery

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

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff were very proud of the feedback their patients gave. Staff supported patients to make informed decisions and advanced decisions about their care. Patients gave positive feedback about the service. Patients we spoke with gave positive feedback about their experience of Buckshaw Hospital and how they had been involved in decision making about their care.

Is the service responsive?

Good

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

Service delivery to meet the needs of local people

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

Leaders planned and organised services, so they met the needs of the local population. The service was working with local NHS services to see NHS patients to help alleviate the 'backlog' in referrals locally, as arranged with local commissioners.

Appropriate service level agreements were in place for the NHS services that were delivered at Buckshaw Hospital.

Leaders monitored and took action to minimise missed appointments. All patients received appointment reminders prior to their appointment. Leaders ensured patients who did not attend appointments were contacted. Administration staff rebooked appointments for patients who did not attend. When patients did not attend their appointment twice, clinicians reviewed the case notes before patients were referred to their GP.

The hospital had an onsite physiotherapy team who offered support to patients who were recovering from surgery. In addition to individual sessions, they also ran group pilates sessions for patients and staff.

Pre-operative assessments were being carried out on the same day as outpatient appointments where this was appropriate. This meant patients were not having to return to the hospital unnecessarily for a second appointment. This process had been in place since the hospital opened in 2021 so leaders were not able to evidence how this had improved services for patients. However, we saw some examples of very positive feedback that patient had left about the service.

Meeting people's individual needs

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

Good

Surgery

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The policy provided clear guidance on assessment of needs, support required in order to comply with the Accessible Information Standard, formally known as DCB1605 Accessible Information.

The service had access to information leaflets available in a variety of languages and formats. We saw information leaflets for specific procedures displayed in the patient waiting area.

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

The hospital had recently had an incident where an interpreter had not been booked for a patient attending for an appointment. As a result of learning identified from the incident a standard operating procedure for booking interpreters had been created and was due to be ratified for use at the time of our inspection. All staff could follow the guidelines to book an interpreter but in addition, 3 members of the hospital administration team were listed as pointed of contact for interpreter bookings.

Patients were given choice of appointment times to meet their needs.

The hospital had clear exclusion criteria which identified patients who would not be suitable for surgery at Buckshaw Hospital. All patients were triaged at the point of listing. Any patient that did not meet the admission criteria was informed of the reason and referred to an appropriate service. Any clinical concerns relating to the patient's fitness to proceed to surgery was escalated for anaesthetist review and/or consultant surgeon, as appropriate.

The hospital had a hearing loop in the reception area to support patients with hearing loss. However, it was noted in the Customer Focus Group meeting in February 2023 that very few staff knew how to use it. Staff training for this was being arranged.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards. However, NHS patients did not always receive treatment in a timely manner due to the delays they experienced on NHS waiting lists before being transferred to Buckshaw Hospital.

Leaders monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Leaders used a clear clinical prioritisation process to review the waiting list periodically and actively sought the views and wishes of patients. The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment (RTT).

The hospital followed the providers waiting list policy. This outlined how waiting lists for NHS and private patients were managed and referred to the NHS standards.

In March 2023, 55% of patients were seen within 18 weeks and the average waiting time from referral to treatment was 15.3 weeks. There were 3,608 patients on the waiting list. Of these 3,608, 167 patients had waited more than 52 weeks and 9 patients had waited more than 78 weeks. 1193 patients were waiting for general surgery.

At the time of our inspection, only 1 patient on the waiting list was a private patient. Less than 100 patients on the waiting list were direct NHS referrals from a GP to Buckshaw Hospital. All other patients had been transferred across from a local

NHS waiting list where they had already waited for a period and had been transferred to Buckshaw Hospital so they could be seen more quickly. The waiting time 'clock' was not restarted when patients were transferred to the Buckshaw Hospital waiting list. Leaders understood this mechanism in place to support the reduction in NHS waiting lists meant that Buckshaw Hospital waiting times were not accurately reflected in the RTT data. However, they demonstrated a dedicated approach to supporting NHS patients to access care in a timely manner.

Information provided by the hospital showed that waiting times for outpatient appointments at the time of our inspection were:

- ENT 36 days
- Gastroenterology 4 days
- Gynaecology 254 days
- Urology 22 days
- General Surgery 36 days
- Orthopaedics 9 days

Information provided by the hospital showed that waiting times for surgery at the time of our inspection were:

- ENT 30 days
- Gastroenterology 14 days
- Gynaecology 85 days
- Urology 85 days
- General Surgery 14 days
- Orthopaedics 28 days

Leaders worked to keep the number of cancelled treatments/operations to a minimum. When patients had their treatments/operations cancelled at the last minute, Leaders made sure they were rearranged as soon as possible and within national targets and guidance. Cancellations were discussed at daily huddles so leaders could closely monitor the cancellations and actions taken.

Between April 2022 and April 2023, there had been 512 cancellations for non-clinical reasons. It is recognised that during this period there were some peaks in national COVID cases and therefore staff sickness may have had an impact.

Staff planned patients' discharge carefully. The hospital 'patient journey' policy outlined the steps staff should take to ensure that patients were safely discharged.

Staff supported patients when they were referred or transferred between services. Leaders monitored patient transfers and followed national standards.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern or provide feedback in patient areas including quick response (QR) codes for online feedback forms or feedback cards and boxes. Complaints procedure leaflets were also available for patients.

Good

Surgery

The hospital had a policy for the management of patient complaints. The policy outlined the process and timescales for the management of complaints in a 3-stage process. Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from Leaders after the investigation into their complaint.

We reviewed 3 recent complaint response letters and saw investigations of the issues raised were thorough. Leaders investigated and shared feedback from complaints with staff and learning was used to improve the service. Any complaints and compliments were discussed at the daily safety huddles and at handover meetings. All complaints were recorded on a complaints log and were regularly reviewed by leaders. At the time of our inspection, there were no overdue complaints. Leaders described a theme of complaints around admin processes and how to contact the hospital. They had made changes to processes to try to improve patient experience.

Leaders told us all complainants were offered an initial early conversation to understand the issue and to clarify any expectations. Almost all complaints were resolved quite quickly by this proactive approach and rarely did they progress to stage 2 of the hospital's complaints' process.

A member of the senior leadership team completed an audit of complaints in November of each year.

The hospital has subscribed to the Independent Sector Complaints Adjudication Service (ISCAS). ISCAS provides independent adjudication of complaints when required.

Leaders told us Buckshaw Hospital had been a complaints outlier when compared to other locations owned by the provider in the last year as they received 38 complaints; 25 of which related to the surgical department. However, leaders were aware of this and that they were working to improve this. Reducing the number of complaints was part of the governance workstream in the new clinical strategy for Buckshaw Hospital.

Is the service well-led?

Good

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

Leadership

All leaders had the skills and abilities to run the service. They fully understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The hospitals' leadership team comprised of a Hospital Director who was the Registered Manager, an Operations Manager, a Head of clinical services and a Finance Manager. Each department in the hospital also had a Head of Department who also worked clinically with their teams.

All leaders we spoke demonstrated a good understanding of the service and a passionate and committed approach towards the future of the hospital. They appeared to be a very cohesive team working hard for the benefit of all patients, staff and their service. We saw examples of patient feedback which included positive comments about some of the heads of department.

Good

Surgery

The senior management team were experienced, visible, supportive, and clearly knew their staff and their patients. Leaders worked very closely together and shared their knowledge and skills to support each other and the wider staff team. Leadership development training was available from the provider.

Leaders were proud of their joined-up approach and cross working with other sites owned by the provider. They had an ambitious vision for the future and stated they were very proud of their staff. Recruitment and retention were a concern to leaders but they had plans to address this.

The Hospital director had recently taken on this role for Buckshaw Hospital. Despite only being in post for approximately 4 months, staff spoke very positively of the visibility, support and positive change that the Hospital director had provided.

Consultants were fully engaged and committed to deliver the best possible services for their patients. Consultants reported feeling supported and any issues they highlighted were dealt with quickly.

Leaders were proud of each other and the feedback they received from staff. Leaders had a nurturing and developmental approach to support all staff.

Buckshaw hospital had recently gone over budget due to the procurement of additional services to reduce waiting times for patients in some departments. There were plans in place to quickly recover from this financial deficit and it was positive to see that leaders were considering patient needs when making financial decisions.

Vision and Strategy

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

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

The values of the provider were well embedded and we saw staff and leaders demonstrating these values during our inspection.

- 'we are caring'.
- 'sustainability'.
- 'work together'.
- 'we have pride'
- 'value people'.
- 'positive outcomes'.

The hospital had a strategy in place with a focus on developing the services provided within the hospital. The strategy had nine focus areas:

- Establish the quality and safety of care of patients and families.
- Implement corporate skill projects.
- Skilled knowledgeable and motivated workforce.
- Utilisation of the treatment room.
- Transform clinical care and outcomes through collaborative working.

- Clinical multidisciplinary working.
- Embedding governance processes.
- Anaesthetic cover.
- Working towards and outstanding CQC rating.

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

Not all staff we spoke with were aware of the hospital values and strategy. However, during our inspection these were on display throughout the hospital.

Culture

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

Staff at all grades, were always very friendly and very welcoming and we had open and honest conversations with a variety of staff across the service. We saw there was a real community feel to the hospital. Leaders promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. There was a very strong sense of teamwork which encouraged candour, openness and honesty. Staff spoke of an inclusive and supportive culture.

Buckshaw Hospital had embedded the 'Speaking up for Safety' (SUFS) programme, developed by an internationally recognised healthcare safety organisation. SUFS was a programme to build a culture of safety and quality by empowering staff to support each other and raise concerns. SUFS formed part of the mandatory training for all staff and informed discussions at the daily huddle which had representation from all areas of the hospital. Leaders appropriately addressed behaviour that undermined patient, and staff safety. Leaders proactively supported all staff to raise awareness and drive improvements across the whole hospital.

The hospital followed the providers policies for SUFS and whistleblowing. The policies contained processes that staff could follow to constructively challenge issues 'in the moment' or raise concerns with leaders. Staff we spoke with demonstrated awareness of both processes.

Throughout our inspection, leaders demonstrated a committed approach to staff wellbeing. In addition to the corporate occupational health support and employee assistance programme, they had introduced some wellbeing initiatives such as free fruit for staff each morning and access to mindfulness and Pilates sessions in the physio gym. Qualified mental health first aiders were available for staff to access at Buckshaw Hospital. Staff also had access to a trained counsellor who was available for 1:1's when required.

Leaders held various celebration/awareness days which staff were encouraged to lead and take part in. In addition, staff were asked to nominate a charity each year that would be supported throughout the year through fundraising events. Leaders recognised staff successes and had introduced a recognition scheme called the 'Chorley Champ' which staff were encouraged to use to recognise excellence amongst colleagues. At the end of each month, staff were rewarded with an event called 'month end madness'. We heard about examples where food trucks, and car valets were provided for all staff.

Good

Surgery

All leaders at the hospital had recently started face to face training in workforce equality and 'inclusion for Leaders'. Leaders demonstrated an inclusive approach and a commitment to making reasonable adjustments to meet the needs of staff.

The hospital had policies for equality and human rights, and equal opportunities and diversity. The policies outlined behaviours that staff and leaders were expected to demonstrate and referred to the providers vision 'to have compassionate inclusive culture at all levels'. Relevant legislation was included in the policy such as the protected characteristics and the Equality Act 2010. The policy also included details of how breaches of the policy would be managed.

The provider was running an international recruitment campaign. Leaders were allocating new staff in groups of 4 to 6 people per location to try to prevent them feeling isolated. A package of support was in place for international recruits which included support with accommodation and information about the local area such as GP practices and faith groups.

The hospital had 5 staff focus groups which included wellbeing and diversity. All staff were encouraged to take part in these groups to support Buckshaw Hospital to be an inclusive environment which could meet the individual needs of patients and staff.

Following our inspection, we were contacted by 2 anonymous whistle-blowers from Buckshaw Hospital. They raised concerns about the leadership and culture within the service. This information did not reflect the feedback from all other staff members that we had spoken to and our observations during the inspection. In addition, we saw leaders engaged with staff through regular meetings and a staff survey. Leaders told us how they understood the challenges they had faced around culture and retention of staff, and action had been taken to improve this.

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.

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

- Quarterly Health and Safety Meetings chaired by the Hospital director.
- Quarterly Clinical Governance Committee Meetings chaired by the Head of clinical services with 8 subcommittees meeting monthly.
- Monthly Integrated Governance Committee meetings chaired by the Hospital director to review incident trends and complaints,
- Monthly Senior Leadership Team chaired by the Hospital director meetings discussing quality, safety and risk.
- Monthly departmental meetings with Head of Departments (HODS).
- Weekly provider Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017 meetings

There was a MAC with a chair, vice chair and 8 members. Meetings took place every quarter and there were clear terms of reference in place. We reviewed the MAC meeting minutes from November 2022 and February 2023. Meetings were well attended and had a structured agenda which included relevant topics such as practicing privilege compliance and approval, new clinical processes for sign off and any areas on concern. The chair of the MAC also attended a national MAC arranged by the provider every 3 months.

Good

Surgery

We reviewed a variety of meeting minutes from the departmental meetings, integrated governance meetings, clinical effectiveness and audit group meetings and clinical governance committee meetings. All meetings were well attended and had structured agendas which included relevant topics such as incidents and feedback received, and issues raised. Meeting minutes included clear actions to be taken forward and these were followed up at subsequent meetings. All members of staff we spoke with were aware of the governance structure.

Policies were mainly provider driven, with local appendices or additions where necessary. Any policy changes were discussed at relevant meetings, shared with heads of departments and staff were required to sign to say they were aware of the changes. All policies we reviewed were comprehensive, fit for purpose and in date.

A structured audit programme was in place for each department within the hospital. It was clear when audits were due, the frequency of completion and who was responsible for them. Audits and related action plans were discussed each month at the clinical effectiveness and audit group meetings. In the 12 months prior to our inspection, 197 audits had been completed at Buckshaw Hospital. One hundred and eighty-four of those audits had a compliance score of 90% or above and 117 had a 100% compliance score.

Service level agreements were in place between the hospital and third parties for services such as sterilisation of equipment, laboratory support, waste management and theatre deep cleans.

Management of risk, issues and performance

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

At the time of our inspection, risk registers were held on spreadsheets at department and hospital level but there were plans for them to be moved to a new electronic risk management system. The hospital had a clear policy which outlined which departmental risks would be escalated onto the hospital risk register.

Risks were assessed using a matrix, and staff and leaders worked to reduce the level wherever possible. Those with a risk score below 9 were managed at department level. Risks scored 9 to 14 were escalated to the hospital senior leadership team and the Information Governance Committee. Risks scored 15 to 25 were considered extreme risks and were escalated to the provider governance committee.

We reviewed the departmental risk registers for all departments, and the hospital wide risk register. We saw risks were appropriately identified, scored in terms of impact and likelihood and that measures were in place to reduce the risk. All risks had been recently reviewed and it was clear who was responsible for the risk.

We saw the risks reflected the concerns described by staff and leaders in the service. Staff knew how to report and escalate risks. The risk registers were routinely discussed at governance meetings and departmental meetings.

A fire risk assessment had been completed for the site by a third-party contractor. This fire risk assessment was valid until September 2023. We saw an action plan in place for the 8 findings from the risk assessment. Six actions were complete, and 2 low risk actions were awaiting attendance by an external contractor which was planned for June 2023.

The hospital had a comprehensive business continuity plan which outlined action plans for staff to follow in the case of a disruptive incident such as a loss of power or structural defects. The policy included contact numbers for relevant people or services which could be used to escalate or resolve issues.

Good

Surgery

The hospital had a lone worker policy which outlined the actions that were required to keep staff safe if they worked alone. The policy referenced relevant national guidance such as the Health and Safety Executives 'INDG73 Protecting lone workers' guidance.

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.

Staff received helpful data on a regular basis, which supported them to adjust and improve performance as necessary. Staff had access to up-to-date, accurate, and comprehensive information on patients' care and treatment. Staff were aware of how to use and store confidential information.

The provider had a secure intranet where staff could access policies and other information to help them to perform their role.

The service had reported no data breaches since the hospital opened.

An audit against the requirements of ISO 27001:2013 (an international standard to manage information security) had been completed by a third-party contractor in September 2022. The audit found the hospital management systems met the required standards, and no areas of non-compliance were identified.

Backup power for the IT provision and the hospital was via an uninterrupted supply and a generator. A contract was in place for the servicing and maintenance of this.

Patient records were mainly electronic, and data was backed up regularly to a secure data centre.

Laptops used by some staff and leaders were encrypted and remote access to the systems was via a virtual private network (VPN) with multifactor authentication.

Engagement

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

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

We reviewed the staff survey results from November 2022. This was done collaboratively with another Ramsey hospital and the data could not be broken down any further. 79% of staff said their immediate manager was available when needed. 61% of staff said they had good opportunities for learning and development at work. 60% of staff felt proud to work for the organisation. Overall, all staff survey results had improved since the 2021 survey. Following the staff survey, leaders had created an action plan in response to the results which included holding some focus groups with staff to understand any areas for improvement in more detail.

Good

Surgery

All staff we met on inspection said it was a good place to work, with good support from management. All staff said they felt comfortable to speak to the hospital management team. They also knew the names and who the senior team were.

The hospital director held monthly staff forums which heads of department did not attend so staff had the opportunity to raise any concerns about the management of departments. The hospital director also sent weekly updates out by email to all staff.

The head of clinical services led a monthly customer focus group meeting. The meeting was attended by a representative from each department. This group has previously been held jointly with another Ramsey hospital but in the last month had been split into separate meetings. Buckshaw Hospital were in the process of identifying patient representatives to attend this meeting. The meeting reviewed all patient feedback and identified actions that could be taken to improve patient experience.

Prior to opening the facility in 2021, the hospital had invited services users into the building to test the environment and the patient pathway for suitability. This included service users with protected characteristics to ensure the environment met the needs of all service users.

Leaders were engaging with local NHS trusts to support the reduction of patients who had waited over 52 weeks for treatment. The provider had approved funding for a member of staff to review and triage patients on the NHS waiting list at one local trust to identify patients who were suitable for treatment at Buckshaw Hospital.

Leaders also engaged regularly with other external stakeholders to monitor performance and identify any areas for improvement.

The hospital leaders and staff were passionate about supporting and engaging with the local community. They had raised £482 for local charities, donated parcels to the local food bank, donated gift bags to a local children's home and taken part in a Christmas gift bag appeal with a local charity. Buckshaw Hospital also sponsored the local Lancashire Football Association Disability League.

Learning, continuous improvement and innovation

Leaders encouraged innovation and improvement. All staff were committed to continually learning and improving services. However, staff did not receive training in quality improvement.

There was an employee innovation group at the hospital. The meetings were staff led and were focused on driving improvement. The group fed back any ideas or themes to the hospital director. We reviewed the minutes from the meetings in February and March 2023. The meetings were well attended, had a structured agenda and an action plan. Although we saw staff were making suggestions for improvement which were reviewed and actioned by the hospital director, we did not see any quality improvement projects or clinical innovation.

Throughout the summer of 2022, leaders had held 'Lunch and Learn' events for staff to attend where learning sessions were provided as needed.

The hospital had two leads for innovation and improvement- 1 receptionist and 1 governance lead. However, we did not see that these leads had received any additional training in quality improvement.

Good

Diagnostic imaging

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

Is the service safe?

Good

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

Mandatory training

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

Staff received and kept up to date with their mandatory training. The service compiled this data for all hospital staff, it was not broken down into departments. Please see the surgery report for more information on compliance rates for mandatory training.

Most staff from the diagnostic imaging department told us they were given time to complete their training within working hours. Staff confirmed that once a month they were given time from clinical activity to complete mandatory training.

The service provided additional training including safety induction training for all radiology staff.

Staff had completed cardiac arrest simulation training in the Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) departments in February 2023. The diagnostic imaging head of department reviewed the learning from the training and had since implemented the recommendations.

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

Safeguarding

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

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

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us they would inform a named safeguarding lead that was available on site. Staff told us they felt comfortable raising safeguarding concerns relating to their personal lives or professional lives with the safeguarding leads. They were aware of how to access referral forms on the trusts internal drive on the computer system.

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

The service had flowcharts throughout the hospital with instructions of how to report concerns about abuse and safeguarding information on posters was observed in the patient toilets.

Chaperones were offered to patients for any procedure, regardless of whether the person conducting the procedure was of the same gender as the patient.

For further information see information under this sub heading in the surgery section.

Cleanliness, infection control and hygiene

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

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. The service scored 100% on the patient led assessment of the care environment (PLACE) for cleanliness and the condition, appearance, and maintenance of the hospital in 2022.

The diagnostic imaging department and endoscopy service performed well for cleanliness. The diagnostic imaging department scored 100% for February, March, and April 2023 for departmental cleaning. Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. We saw daily cleaning records, which had been completed for the month prior to the inspection and cleaning checklists in the patient toilets were up to date. We saw evidence that theatre cleans took place immediately after the completion of endoscopies. The service had not had any healthcare associated infections since they had registered with the CQC.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff following the infection prevention control policy and wearing the appropriate PPE. Clinical staff were bare below the elbow in clinical areas and used hand sanitiser between patient contact. Diagnostic imaging staff had scored 100% compliance in the hand hygiene audits carried out in February, March, and April 2023.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff decontaminated endoscopes between patients and at the beginning and end of each list, in line with the service's policy on the management and decontamination of flexible endoscopes. There was a clear workflow within the department from dirty to clean to avoid the possibility or recontamination of endoscopes. The patient changing areas had privacy curtains which had been cleaned in November 2022 and were changed every 6 months.

Staff did not always follow the best practice guidance regarding the disinfection of transducer probes. They did not always record the serial number of the probe which meant that there would be no way to differentiate which probes were used on which patients if staff were to swap to the spare probe.

Good

Diagnostic imaging

The service completed 2 audits for hand hygiene but did not have the World Health Organisation's (WHO) "five moments for hand hygiene" advice above the sinks in the department. This acts as a reminder to staff and patients to clean their hands correctly to stop the spread of germs.

Environment and equipment

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

The design of the environment followed national guidance. The diagnostic imaging service ensured there was access to a helium vent pipe on the roof which was securely controlled by the maintenance team. There were clear MRI and CT safety signage on the doors of the units, however we did not see names or contact details for the RPS or Radiation Protection Advisor (RPA) which should be observable for patients.

The department was secure, only staff with a swipe card could access the area. The mammography area had a digital door lock which staff needed to enter a code to access. We saw there had been a recent incident in which a patient had entered the department without swipe access. This was identified at the engagement and innovation group meeting in March 2023 and had been addressed when we completed the inspection.

Staff carried out daily safety checks of specialist equipment. The MRI scanner had a daily and weekly quality assurance check by an authorised person and MR safety expert which was supervised by a radiology superintendent. We saw evidence of regular quality control checks on the scanners from the last 6 months. The mobile x ray machine had not been used for patient x ray since the hospital had opened but was still maintained, serviced and quality assurance tests were completed. Staff completed testing of protective lead tops, aprons, skirts, and collars, as well as monthly spot checks. We saw evidence of service contracts for the equipment used on the department which were in date. All equipment we checked for use on the MRI scanner was labelled in line with the Medicines and Healthcare Products Regulatory Agency (MHRA) recommendations.

The department had suitable facilities to meet the needs of patients. Patients had access to an emergency call buzzer and could communicate with staff through an intercom system during their scan. Patients had accessible toilets and a changing area which consisted of a locker, wipeable chair, gowns, a mirror, and a linen bin prior to scans. Post colonography patients had access to a recovery room. A cannulation area with a cannulation chair and cannulation trolley was available for patients attending MRI scans.

Staff had enough suitable equipment to help them to safely care for patients and themselves. We saw evidence staff had received the appropriate training, instructions and information for equipment used including the MRI scanner, mammography machine and CT scanner. Staff could quickly access the resuscitation trolley, which was checked daily and weekly. The resuscitation trolley was fully stocked apart from safety goggles, this was raised to staff on inspection. Staff had equipment to check patient's kidney function to ensure the MRI was safe to go ahead (the dye used during the scan can cause further damage to the kidneys). Staff undertaking CT had radiation exposure monitors, which managers monitored the results of.

The service had a fire risk assessment which was valid between September 2022 and September 2023. The risk assessment identified sources of ignition, fuel, and people at risk in each department including diagnostic imaging. Firefighting equipment seen was fit for purpose.

We checked a range of electrical equipment; our observations and documentation confirmed all the equipment had been safety tested.

Staff disposed of clinical waste safely. Sharps bins were dated and labelled correctly.

We checked a range of consumables which were all in date and packaged correctly. In the CT stock room, we saw storage pump injector syringes and a cardboard box on a trolley which should have been stored away in a cupboard.

The department completed control of substances hazardous to health (COSHH) risk assessment documents for individual substances which were used on the department. All COSHH chemicals were stored securely and appropriately in locked cupboards with restricted.

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 were knowledgeable about what actions they would take to identify and respond to a deterioration in a patient's health which was in line with their recognition and management of deteriorating patient policy. There were emergency buttons in the scanning rooms which alerted the 'crash team' which consisted of a resident medical officer who had advanced life support training, 2 members of staff from the department with intermediate life support training and a 'runner' with basic life support training. A staff member from the 'crash team' came to the department each day to update the staff on who was available for support. There were agreed and recorded protocols for the transfer of patients to NHS care in the event of complications. The service had established links with local NHS trusts.

Radiography staff explained if an anomaly was identified on a scan and immediate attention was required, this was escalated on the provider's internal information system which ensured a radiographer reviewed the scan urgently.

The department had a pregnancy procedure; flow charts; a sex, identity, gender, and expression form; a pregnancy declaration form and a disclaimer where there was a possibility of pregnancy to ensure the pregnancy status of women who were having scans was identified. The local rules outlined the RPA, or the safety experts would offer advice on the risks of scans for pregnant women to the patients or staff if required.

Radiographers had oversight of all referrals and would decide on the urgency and necessity of a scan before an appointment was agreed upon.

Staff shared key information to keep patients safe when handing over their care to others, when anomalies were identified by the radiographer, this was shared with the diagnostic head of department who would contact the referring clinician.

Radiography staff told us contrast scans were limited from 9am to 5pm to ensure a resident medical officer would be available to support them. We observed a patient who had a contrast reaction whilst we were on site. Staff monitored the patient in a consultation room on the department and completed an assessment of the reaction before allowing them to be discharged.

The hospital had 2 radiation protection supervisors (RPS) on site and an RPA based at a nearby hospital. RPS's are required where employers work with ionising radiation and where a controlled area exists. They ensured the department worked with ionising radiation in accordance with the local rules. The RPA provided advice to staff, including the RPS's on complying with the Ionising Radiations Regulations (2017) (IRR17).

Good

Diagnostic imaging

The staff followed the Society of Radiographers "pause and check" process. We observed staff asking for the patient's name, date of birth and address when they were taken from the waiting room and before their scan. We saw "pause and check" posters throughout the service.

The service had mental health first aiders. These staff members were identified at the daily huddle and could be utilised by staff if they needed support with patients with mental health difficulties.

Radiologists told us they were contactable for staff queries outside of normal hours by mobile phone but were not officially "on call".

Some staff were unsure of the effects of electromagnetic fields on their personal health and were unaware of any training they have had on this as required under the Control of Electromagnetic Fields at Work Regulations (2016).

The service had copies of local rules throughout the department. The local rules summarised instructions to restrict exposure in radiation areas. However, the local rules in the MRI room had not been updated with the new RPA contact details.

Radiographer 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 agency staff a full induction.

The service had enough staff to keep patients safe. The service employed a radiology manager who was qualified in MR and CT and would support staff clinically when required, 3 health care assistants, 2 of which were full time and 1 who worked between Buckshaw Hospital and a local hospital, 3 full time radiographers and 2 part time radiographers (2 of which were trained in MR and CT whilst the remaining 3 were trained in MR), 2 regular agency staff who completed CT scans and ultrasound vascular scans, 2 full time administrative staff and 1 part time administrative member of staff.

The mammography department employed 2 mammography full time radiographers, 1 of which was on parental leave. They also utilised 2 bank mammography radiographers, 1 of whom was in the midst of their training.

Consultant radiologists worked under practicing privileges meaning they completed their medical revalidation and continuous professional development in the NHS trust where they worked. These records were checked by the director of the hospital as part of the providers 'Facility Rules'.

The department had reducing vacancy rates. The service had 1 vacancy which was a matron post. This was being covered by an interim matron at the time of the inspection.

Managers made sure all bank and agency staff had a full induction and understood the service before working without direct supervision.

The service used a rostering service which accurately calculated and reviewed staffing numbers.

The service had low sickness rates. Overall, the staff sickness rate between March 2022 and March 2023 was 5.8%.

Good

Diagnostic imaging

The service had an overall turnover rate of 22.5% from March 2022 to March 2023. Staff on the diagnostic imaging department had informed us that staff turnover had been high but felt their clinical team was now well established and the turnover of staff would now ease.

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 service used electronic and paper systems for patient records. A daily log of scans was kept by staff and recorded on the radiology information system (RIS).

Patients' informed consent forms for pregnant patients were scanned on to the patient's record.

Staff used a password protected picture archiving and communication system (PACS) to store records and images. Information about imaging was stored on RIS.

Staff told us scans were deleted off the scanner once a report had been produced.

We checked 8 patients records and found each had a completed referral form, prescription, safety checklist and contrast checklist.

Medicines

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

Patients who were being administered contrast were provided with a patient safety questionnaire to complete which contained 5 forms of ID which were name, date of birth, address, patient number and NHS number. The questionnaire asked about previous reactions to contrast, previous or current diagnoses and pregnancy status among other topics. We observed a staff member going through this form with the patient. We saw 8 completed questionnaires which the patient and radiographers had signed.

Patients who had a contrast reaction were given a form they could share with their GP with details of the reaction and any complications.

Medicines that were stored included Omnipaque, Buscopan, Chlorpheniramine Maleate, Lidocaine, Iomeron and Gastrografin. All medicines were within manufacturers expiry dates.

The service had standard operating procedures for medical gases such as Nitrous Oxide and carbon dioxide used in endoscopy.

Contrast medium medicines, used for ultrasound investigations, were stored in a locked cabinet and the temperature was monitored. However, we did see some contrast medium in a technical room which was air conditioned, but the temperature was not monitored.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Good

Diagnostic imaging

The service reported 25 clinical incidents relating to diagnostic imaging in the last 12 months, 5 of which involved radiation. None of the incidents required them to be submitted to the ionising radiation (medical exposure) regulations (IRMER) team.

Managers and governance staff investigated incidents thoroughly. We reviewed the last 3 incidents for the department. We observed a methodical approach which provided insight into the root cause, actions and changes made. We could easily track incidents from initial reporting to the conclusion stage.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the service's policy. Staff reported any incidents on the hospital's electronic incident reporting system which were then reviewed by the manager of the department and radiology governance team. Incidents were closed by the matron once fully investigated.

The department had incident flowcharts visible in most rooms which highlighted actions for staff to take if there was an equipment fault or procedural error.

The department had systems in place for radiation related incidents to be escalated to and investigated by a medical physics expert.

The service had no reported never events. Never events are serious incidents that are wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available, at a national level, and should have been implemented by all healthcare providers.

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

Staff received feedback from investigation of incidents, both internal and external to the service. An email was sent monthly from the provider regarding radiology incidents and lessons learned. Staff signed a register when they had read it. We also saw lessons learned documents on the walls of the service for staff to read.

Is the service effective?

Inspected but not rated

This was the first inspection of this core service. We do not rate effective for diagnostic services.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Radiology staff adhered to national Ramsey Health Care UK policies in accordance with the RPA and Ionising Radiation (Medical Exposure) Regulations IR(ME)R guidance and requirements.

Good

Diagnostic imaging

The departments policy on "Ionising Radiation Safety" included details on the 'local rules and the roles of the RPS and RPA in line with Ionising Radiation (Medical Exposure) Regulations (2000). Hard copies of 'The local rules', which summarised instructions to restrict exposure in radiation areas, were seen throughout the department, however the MRI variation had not been updated with the new RPA contact details. Staff working in designated radiation areas signed a statement that they had read and understood the 'local rules'.

The hospital had 3 radiation protection supervisors (RPS) on site and an RPA based at a nearby hospital. RPS's are required where employers work with ionising radiation and where a controlled area exists. They ensured the department worked with ionising radiation in accordance with the local rules. The RPA provided advice to staff, including the RPS's on complying with the Ionising Radiations Regulations (2017) (IRR17).

The department took part in local hospital-based audits including hand hygiene technique and observation, department cleaning (49 steps), medical records, non-medical referrer documentation and records, national safety standards for invasive procedures, CT last menstrual period and MRI safety. We reviewed local audits for the department for 2023 and found they had not scored under 93%.

The service had local diagnostic reference levels in place. Diagnostic reference levels are specified radiation doses that are not expected to be exceeded. The RPA used national diagnostic reference levels to calculate the local CT diagnostic reference level.

The mammography service ensured breast screenings had 2 radiologists reviewing mammograms known as 'double reading.' This was in accordance with the European quality assurance guidelines for breast screening.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

Nutrition and hydration

Patients were advised to fast if required. Staff gave patients food and drink when needed.

Patients were given advice for certain types of procedure which needed them to fast.

Staff provided patients with prepacked biscuits, warm drinks and water if needed. This was routinely offered for patients undergoing colonography scans.

The service had a crash trolley which provided glucose to help diabetic patients if needed.

Pain relief

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

Patients having scans do not routinely require pain relief. Staff did monitor and check patients pain verbally throughout their scan or appointment and could seek support from medical staff if needed.

Staff were aware of how to escalate concerns with senior colleagues if they had concerns regarding a patient's ability to communicate pain to them.

Patient outcomes

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

Good

Diagnostic imaging

Outcomes for patients were positive, consistent, and met and often exceeded the provider's average. Between the 1 May 2022 and 30 April 2023, 126 patients responded to the 'Friends and Family Test' which is a feedback tool sent to every patient to review the service, 99% of NHS patients and 100% of private patients reported to have had a good experience of the diagnostic imaging service.

The service also inputted to the national Private Healthcare Information Network (PHIN) to improve patient outcomes. We saw evidence of how the service had analysed the data from endoscopy patients experience of the hospital and had identified the key themes that would need to be addressed.

The service took part in clinical audits. We saw evidence of an image quality audit from December 2021 to May 2022 in which 27% of images were reviewed for 2 mammographers. No issues were identified with the quality of the images.

Competent staff

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

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. We reviewed 3 radiographers staff records whilst on site and they all had evidence of professional registration, a valid disclosure and barring service certificate (DBS), qualifications and curriculum vitae's (CV's). Staff completed competency assessments in areas such as CT, MRI and for the electronic systems used before they could work independently. Staff had access to mandatory training, additional training, and continuous professional development.

Managers gave all new staff a full induction tailored to their role before they started work. New staff had regular 1 to 1's with their manager for the first month to review their progress. Following that a 3 monthly review was completed. Staff were provided with a handbook, an induction checklist and learning logs to maximise the retention of learning.

Managers ensured agency and bank staff had checklists which ensured they were aware of the key information on the department before starting their shift. This included where the crash trolley was situated and where the resident medical officer was based.

Managers identified any training needs their staff had and offered lead roles to staff. Most staff said they had time to develop their skills and take on their lead roles.

Managers identified poor staff performance promptly and supported staff to improve.

The service granted 'Practicing Privileges' following processes detailed within the providers 'Facility Rules'. See the surgery report for further information.

Staff told us the department had regular meetings. We requested meeting minutes from the last 6 months but only received evidence of 1 meeting from February 2023 which the hospital director informed us did not meet the standard agenda due to the recruitment of a new radiology manager.

Staff did not always complete their personal development reviews on time. From the data we received on appraisal completion rates for the department we found 50% of the staff had not completed their yearly appraisals, this was not including staff that had left the service, staff on parental leave or new staff who were due to have their personal development review. The numbers of staff in each department were low which meant that overall compliance was heavily impacted by each out of date PDR.

Good

Diagnostic imaging

The provider did not complete radiology reporting audits but did audit 10% of CT and MRI scans that had been referred by an international healthcare company as part of their requirements. Radiology reports which needed these audits were completed 3 times a year and second reported by a telediagnostics platform.

Multidisciplinary working

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

Staff told us they had a good working relationship with referrers and the outpatient's department. Routine communications between the service and the referrers were necessary and ensured scan results were being fed back to the patient.

The service included the input of radiologists, consultants, and clinical assistants. Staff said they had good working relationships as a team. Staff told us they worked well together, and this was supported by an effective and approachable manager.

We observed imaging staff working well as a team and demonstrating their knowledge of each other's roles.

The department had representatives who attended the daily huddle. Staff stated this was well attended and helped to keep them informed. Issues discussed in the daily huddle were communicated to staff by email.

Seven-day services

Key services were available to support timely patient care.

The departments working hours were Monday to Friday from 8am until 8pm and Saturday from 8am until 8pm.

CT scans were offered on Mondays and Tuesdays from 8am until 8pm.

MRI scans were offered from Monday to Saturday from 8am until 8pm.

The mammography service was available on Thursdays and Fridays from 8.30am until 4.30pm.

Ultrasound scans were offered on a Monday from 8am until 6pm (Doppler ultrasound), Tuesday afternoons from 2pm until 5pm, Wednesday afternoon from 2pm until 4pm, Thursdays from 8.30am until 5.30pm and Fridays from 8am until 12pm.

Health promotion

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

See information under this sub heading in the surgery section.

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.

Good

Diagnostic imaging

The service had an up-to-date policy which staff followed regarding consent to treatment for competent adults and children/young people. It provided guidance on mental capacity, consent and the processes involved.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We reviewed records and spoke with patients who confirmed staff gained consent from patients for their care and treatment in line with legislation and guidance.

Staff explained assessments for mental capacity were normally completed prior to the patient attending for a scan. Staff said if they had concerns regarding a patient's capacity, they would seek support from their senior members of staff or the safeguarding leads. Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. See the surgery report for training compliance rates for staff from the service.

Staff provided patients with information relating to the benefits and risks associated with the radiation dose from the exposure.

We observed verbal consent being obtained from patients prior to them having diagnostic tests.

Patients attending appointments for CT colonoscopies were asked to attend the department prior to their appointment so staff could give them patient information leaflets and to take time completing the relevant questionnaires and completing the consent forms.

Patients who needed further investigations would complete a new consent form for these recall procedures.

Is the service caring?

Good

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

Compassionate care

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

Reception staff were professional and provided patients with a warm welcome to the hospital. We observed them respecting patients' privacy whilst booking them in.

We observed staff being polite, professional, and treating patients with respect and dignity.

Patients' privacy was respected. Patients were provided with 'dignity shorts' for intimate scans. The CT room had blinds on the windows from the control area into the scan room that were closed when required.

The service referred to breast mammograms for males as a chest wall examination to make male patients feel more at ease with the procedure. Male patients who had been referred for mammograms were offered the choice of a male or female radiologist to perform their ultrasound scan.

The service ensured patients had access to chaperones.

Patients we spoke with said staff treated them well and with kindness. A patient explained how they had attended the wrong site for their appointment but that staff were flexible and accommodated the appointment running later than expected.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff understood scans can be anxiety provoking for patients and showed understanding and empathy in those situations.

Emotional support

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

Staff understood the impact the patients' treatment and condition had on their wellbeing. We observed staff caring for patients with care and compassion, for example we saw how staff showed professionalism, concern and support for a patient who had a contrast reaction.

Staff told us how they regularly check on patients who are undergoing a scan. They offered encouragement and reassurance for patients.

Staff explained if patients were particularly anxious about their scan, they could offer them a "tour" of the department, show them the equipment, including the scanner and explain the process before their appointment.

Patients told us that staff attended to their emotional needs. They were offered time in the 'counselling room' if they were upset or distressed. The room had a warning light that said 'do not disturb' which deterred others from entering the room.

The service ensured there were staff available who were trained as "mental health first aiders". During the huddle every morning the "mental health first aiders" were identified. Staff from any department could request support from these staff.

The service allowed patients to listen to music of their choice during the scan to lessen their emotional discomfort.

Patients gave positive feedback about the service. We reviewed a sample of the patient's comments from the 'Friends and Family Test' from March 2023. All comments from March were complimentary, some examples included were: "I was very nervous, and they reassured me, the staff were very kind" and "I am claustrophobic, and the staff gave me the time I needed to compose myself to get on the scanner".

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 provided patients with information prior to their scan. Patients told us that this information was informative.

Staff spoke with patients, families, and carers in a way they could understand, using communication aids where necessary. We observed staff explaining the procedure in a way patients understood, and they were given enough time to ask questions.

Good

Diagnostic imaging

Staff encouraged patients to complete a feedback form online following their appointment. Comments and survey results were discussed with the aim of improving the patients experience.

Is the service responsive?

Good

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

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the changing needs of the people who used the service. The diagnostic imaging department provided scans 6 days a week and appointments were flexible, including appointments in the evening, to meet the needs of patients. The head of the imaging department told us the service was able to put an additional clinic on for CT scans if there was demand.

Patients had timely access to scanning services and were offered a wide range of standard, complex and contrast-based scans. CT scans were offered 2 days a week and MRI scans were provided 6 days a week. The service offered a mammography service on 2 days a week and a '1 stop' mammography service 1 day a week. The '1 stop' mammography service was offered to patients who were asymptomatic. Patients were provided with a consultation, a mammogram, an ultrasound scan if needed with results in 48 hours.

Facilities and premises were appropriate for the services being delivered. The hospital had adequate car parking with free electrical charging. Once through reception the hospitals layout was simple for patients to follow. Televisions were observed in the main waiting area and Radiology sub wait area for patients to watch. Additional toilets were situated in the ultrasound room and CT room.

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.

The service had a policy for 'patients who needed additional support to access information and services. This clearly identified the duties of staff within the organisation and had specific recommendations for patients with different needs including dementia and visual impairment.

The services opt in leaflet offered patients with additional needs the option to contact the service to discuss their appointment or any adaptations prior to them attending.

The department made adaptations for patients with disabilities or who had difficulties hearing. They had an MRI compatible wheelchair and Zimmer frames available. Signing interpreters were available for those with difficulties hearing. The scanners also had a light function on them to indicate when to breathe or hold their breath.

Patients with a visual impairment could ask for information to be printed in a larger font and staff would accommodate this.

Good

Diagnostic imaging

Staff invited patients who were anxious about their scans to attend the service prior to their appointment and encouraged them to speak with the staff and their referring consultant about their concerns. The service offered mental health first aiders who could support patients with mental health difficulties. Patients with claustrophobia, were scanned feet-first whenever possible.

The service offered staff dementia awareness, disability training and 'Oliver McGowan' autism training to staff.

The service ensured staff, patients, loved ones and carers could get help from interpreters or signers when needed. The staff were clear they would not allow a relative or friend to sign or translate for patients. The contact information for signers and interpreters was readily available. The MRI and CT scanners had different language settings.

Patients had a choice of music whilst having an MRI scan.

Bariatric patients were invited to the department prior to their scan to check whether the scanner was appropriate. The CT scanner was a wide base scanner. If the scanning machine was not appropriate staff signposted patients to another service to meet their individual needs.

The department did not have information leaflets available in different languages.

Access and flow

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

The department completed 10,997 scans from May 2022 to May 2023. Of those scans, 7,278 were MRI scans and 1,680 were CT scans.

Managers prioritised urgent referrals. The diagnostic imaging head of department told us they would extend clinics or move patient appointments if required to prioritise this patient group.

Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards. However, NHS patients did not always receive treatment in a timely manner due to the delays they experienced on NHS waiting lists before being transferred to Buckshaw Hospital**.** The average waiting times for referral to scan from November 2022 to May 2023 was 6 weeks for MRI, 3 weeks for CT, 2 weeks for ultrasound and 1 week for mammogram. The current waiting times from 2 May 2023 were 3.5 weeks for MRI, 2.5 weeks for CT and ultrasound and 1 week for Mammogram. For private patients waiting times were a week for each modality. Some initiatives had been introduced in 2023 to reduce waiting times. These included mobile clinics being set up at partner sites, shorter appointments in CT (from 1 hour to 45 minutes) and inviting patients earlier for their appointments which ensured preparation for the scan was completed and did not delay further patients.

The average report turnaround times met the provider's key performance indicators. From November 2022 to May 2023 for all modalities the average report turnaround was 4 days, for CT and MRI, it was 5 days, Mammography 2 days and Ultrasound 1 day.

The service had 96 cancellations from November 2022 to May 2023. Of which, 72% of the scans cancelled were MRI. Reasons included a mixture of patient claustrophobia, cancelling of contrast on a day there was industrial action (ambulance strikes) and a scanner breakdown in December 2022. The service had 223 appointments in which patients did not attend (DNA). MRI patients made up 60% of those that DNA.

Good

Diagnostic imaging

Managers worked to reduce cancellations and DNA's. They had a policy for cancellations and DNAs in which patients would be contacted on the first occasion but on the second occasion would be referred back to their referrer. Managers identified themes regarding the data and looked to make changes, for example they found the DNA rates were worse for Saturday clinics, so the service now contacts those patients in advance to remind them of their appointment.

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

Learning from complaints and concerns

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

Patients, relatives, and carers knew how to complain or raise concerns. The department displayed information about how to raise a complaint in patient areas. The provider had a complaints/feedback section on their website which patients could use.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The service would escalate complaints to the Independent Healthcare Sector Complaints Adjudication Service (ISCAS) if a patient was dissatisfied with the service's response to a complaint. ISCAS provides independent adjudication of complaints when required.

The department had 7 complaints between May 2022 and May 2023. Out of these complaints, none were escalated to ISCAS.

Managers investigated complaints and identified themes. We reviewed 3 complaints for the department and found managers had investigated them thoroughly and responded promptly, in line with the complaints policy. Complaints and compliments were discussed at the daily safety huddle meetings.

Is the service well-led?

Good

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

Leadership

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

See information under this sub heading in the surgery section.

Good

Diagnostic imaging

Vision and Strategy

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

See information under this sub heading in the surgery section.

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.

See information under this sub heading in the surgery section.

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.

See information under this sub heading in the surgery section.

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.

Last year the department had lengthy waiting lists and a high turnover of staff. The service identified this risk and had put a peripatetic manager in place to oversee the department. The manager provided support to the newly appointed diagnostic head of department. The service had addressed the waiting lists by using mobile units at another site close by. More comprehensive inductions had also been introduced to new starters as this had been identified as a contributing factor for staff turnover. These measures have been impactful on staff turnover and waits for patients.

Radiation exposure was an identified risk associated with diagnostic imaging. The service lessened the risk by adhering to ionising radiation regulations such as appointing an RPA, a radioactive waste adviser, IRMER duty holders and a medical physics expert. The radiology manager or other RPS's attended the regional radiation protection and medical exposures committee or image optimisation group, among others arranged by the provider.

See information under this sub heading in the surgery section.

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

Diagnostic imaging

The department had access to 24-hour support for PACS. The service planned to update the PACS and RIS in June 2023 and in 2024 respectively. The updated PACS system would allow referrals to be redistributed to another radiologist if the KPI was about to be breached. The new RIS system would be able to provide staff access to key performance indicator data such as DNA rates and cancellations, rather than the administrative staff completing this manually, as they do currently.

See information under this sub heading in the surgery section.

Engagement

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

See information under this sub heading in the surgery section.

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 mammography service had a stereotactic facility for biopsies (a procedure that uses special equipment and imaging techniques to find abnormal areas in the breasts and help remove a tissue sample from that area) which will be used when staff receive training on the equipment.

See information under this sub heading in the surgery section.