Circle Health Group Limited

The Hampshire Clinic

Inspection report

Basing Road
Old Basing
Basingstoke
RG24 7AL
Tel: 01256357111

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

Ratings

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

Summary of findings

Overall summary

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

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

However:

- The critical care service did not have its own governance processes, but the used the ward's governance arrangements. The ward manager represented both services at clinical governance meetings and daily communication cells and was responsible for escalating risks. There was lack of opportunities for critical care staff to meet, discuss and learn from the performance of their service and no formal risk management process in the department.
- A theatre storeroom was found to be visibly dirty and did not appear on the cleaning rota.
- In the theatre environment there was a broken light, held together by tape and glass protecting one set of medical gas switches was broken.
- The sluice area within recovery contained open bottles of cleaning solutions and was cluttered. A sharps bin, without a lid, was being used as a general waste bin.
- Not all staff were familiar with the location of policies, procedures and IR(ME)R procedures.
- The computerised tomography (CT) scan procedures were out of date (March 2020).

Summary of findings

Our judgements about each of the main services

Service	Rating		Summary of each main service
Diagnostic imaging	Good		Our rating of this service stayed the same. We rated it as good because:

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

accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Not all staff were familiar with the location of policies, procedures and IR(ME)R procedures.
- The computerised tomography (CT) scan procedures were out of date (March 2020).

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

Surgery **Good**

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

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

Summary of findings

- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- A theatre storeroom was found to be visibly dirty and did not appear on the cleaning rota.
- In the theatre environment there was a broken light, held together by tape and glass protecting one set of medical gas switches was broken.
- The sluice area within recovery had open bottles of cleaning solutions and was cluttered. A sharps bin, without a lid, was being used as a general waste bin.

Critical care

Good

The critical care service at BMI The Hampshire Clinic was a three bedded unit and provided level 3 and level 2 care and treatment for patients following elective surgery. This was predominantly (85%) for patients having extensive abdominal surgery and intra peritoneal chemotherapy for Pseudomyxoma peritonei, a rare peritoneal cancer. This service was part of the Peritoneal Malignancy Institute in Basingstoke. The remaining 15% of activity was for complex elective surgery. Patients were either self-funded, insurance funded or funded by the NHS through contractual agreements between the hospital and the NHS to carry out NHS work.
At the time of the inspection the critical care unit was closed for a three-week period. As a result we were not able to observe any staff to patient interactions, were not able to speak to patients or their relatives and only spoke to two members of the nursing staff (one permanent staff and one bank staff) and the lead intensivist for the unit.
We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills,

Summary of findings

understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.

- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- 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 using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

However:

- The critical care service did not have its own governance processes but was managed under ward governance processes. There was a lack of opportunities for critical care staff to meet, discuss and learn from the performance of their service and no formal risk management process in the department. They did not proactively identify, monitor and review risks. There were limited mechanisms to engage with patients and the public and staff had limited opportunity to contribute to decision-making.

The critical care service is a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.

Summary of findings

We rated this service as good because it was safe, effective and responsive, although leadership requires improvement.

Medical care (Including older people's care)	Good		Medical care services were a small proportion of the hospital's activity. We looked at endoscopy and oncology as part of this inspection when assessing medical care Our rating of this service improved. We rated it as good • 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 collected safety information and used it to improve the service. • Staff provided good care and treatment, gave patients enough to eat and drink. Managers made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week. • Staff 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. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and all staff were committed to improving services continually.
Outpatients	Good		Our rating of this service stayed the same. 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 collected safety information and used it to improve the service.
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Summary of findings

Contents

Summary of this inspection	Page
Background to The Hampshire Clinic	10
Information about The Hampshire Clinic	11
Our findings from this inspection	
Overview of ratings	13
Our findings by main service	14

Summary of this inspection

Background to The Hampshire Clinic

BMI The Hampshire Clinic is operated by BMI Healthcare Limited. BMI Healthcare became part of the Circle Health Group in December 2019.

The hospital opened in 1984. It is a private hospital in Old Basing, Basingstoke, Hampshire. The BMI Hampshire Clinic provides a range of medical, surgical and diagnostic services to patients who pay for themselves, are insured, or, for some specific surgical procedures, are funded by the NHS.

In the reporting period from September 2020 to August 2021:

- There were 4,136 surgery day cases and 1,774 inpatient episodes of care recorded at the hospital; of these 69% were privately/insured funded patients and 31% were NHS patients.
- There were 204 oncology treatments. All patients were either self-funded or insured.
- There were 1,382 endoscopy patients treated as ambulatory or day cases; of these 59% were privately/insured funded patients and 41% NHS funded.
- There were 32,639 episodes of care in the outpatient department.
- There were 1450 episodes of care in the diagnostic imaging department.

The hospital has 60 registered beds. Facilities include four operating theatres, a three-bed level three intensive care unit, and X-ray, outpatient and diagnostic facilities. There are no emergency facilities at this hospital.

The hospital provides surgery, medical care including endoscopy and oncology, and outpatients and diagnostic imaging. The hospital ceased providing services for children and young people with effect from March 2021 as BMI Healthcare centralised the service.

There were 122 surgeons, anaesthetists and physicians working at the hospital under practising privileges.

The hospital has three wards and is registered to provide the following regulated activities:

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

The hospital has a registered manager who has been in post since August 2019.

We inspected the hospital in April 2018, where the hospital was rated requires improvement overall and we issued three warning notices. After a follow up inspection in January 2019 we found the hospital had met the requirements outlined in the warning notices in full.

During this inspection we used our inspection's methodology to assess treatment and care provided at the service.

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

Summary of this inspection

How we carried out this inspection

During the inspection, we assessed the surgical, endoscopy and outpatients and diagnostics imaging services. We reviewed the overall governance processes for the hospital and report on this as part of the well-led domain. We spoke with 40 members of staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, facilities staff and senior managers. We spoke with 12 patients and observed patient care and procedures with the consent of the patients.

We looked at patient waiting areas and clinical environments, attended staff huddles, looked at 30 patients' care and treatment records, and at hospital policies, procedures and other documents relating to the running of services.

At the time of the inspection the critical care unit was closed for a three week period. As a result we were not able to observe any staff to patient interactions, were not able to speak to patients or their relatives and only spoke to two members of the nursing staff (one permanent staff and one bank staff) and the lead intensivist for the unit.

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

Outstanding practice

We found the following outstanding practice:

- The oncology service had received the Macmillan Quality Environment Mark (MQEM) award in 2020 which identifies and recognises cancer environments that provide high levels of support and care for people affected by cancer. This has been developed in partnership with the Department of Health in England, as it is a core component of the English Cancer Reform Strategy.
- Patient needs and adjustments were highlighted during pre-assessment and followed the patient through their hospital journey.
- The service piloted a translation tool which includes a brief description of the procedures a patient may undertake, available in 22 languages. This drives inclusive and patient focused care.
- The hospital had developed the role of Patient Advocate to provide support to patients, initially during the pandemic period, when patients could not have visitors. This had been developed from the actions of a staff member who had seen patients were alone and decided to provide a friendly face and someone they could talk too. A job description was drafted, and the role was piloted for 3 months with that same staff member.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations.

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

Action the service MUST take to improve:

Summary of this inspection

- The provider must improve governance processes in critical care so there is assurance that the service is managing risk and delivering evidence-based care and treatment. (Regulation 17(2)(a)(b))

Action the service SHOULD take to improve:

- The service should ensure they have a process to identify and repair any damage to the environment.
- The service should consider keeping patient rooms vacant if any repair work is needed.
- The service should consider how to monitor and record expiry dates on water filters.
- The provider should ensure that they are enacting their water safety action plans.
- The service should ensure they have a process to store chemicals and dangerous substances in a way that minimises risk.
- The service should consider a process for storing hospital furniture to enable all corridors to be kept clear.
- The service should ensure they always store patient records securely.
- The service should consider mechanisms to engage with patients and the public to gain their views and opinions.
- The service should consider how it stores policies and procedures to enable diagnostic and imaging staff are able to locate policies and IRMER procedures.
- The service should consider improving access for staff to the CT scanning room.
- The provider should consider changing the practice of using sharps containers as general waste bins.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	Inspected but not rated	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Insufficient evidence to rate	Good	Requires Improvement	Good
Medical care (Including older people's care)	Good	Good	Good	Good	Good	Good
Outpatients	Good	Inspected but not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Diagnostic imaging

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

Are Diagnostic imaging safe?

Good

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

Mandatory training

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

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory and statutory training was provided by a combination of eLearning and face-to-face training sessions. Staff completed 19 mandatory training topics during induction and at intervals of up to three years. This included fire safety, health and safety, information governance and manual handling.

Managers monitored mandatory training and alerted staff when they needed to update their training. The service had an automated system which would alert the manager and the staff when training was due to be completed.

At the time of our inspection, 89.5% of staff had completed their mandatory training against a target of 80%. Staff who were non-compliant had recently started working for the service. Additionally, diagnostic and imaging staff completed targeted training, such as IRMER training, Mammography, Colonoscopy, Radiation Protection, and management & leaderships courses.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Safeguarding children and vulnerable adults formed part of the mandatory training programme. Staff we spoke with told us they had received safeguarding training. Records showed that all staff had completed adult safeguarding training and 93% of staff were also compliant with children safeguarding training at levels two and three. All clinical staff completed level 3 training for both children and adults safeguarding. This was in line with the recommendations from the Intercollegiate Document adult safeguarding: roles and competencies for health care staff (August 2018) and the Intercollegiate Document safeguarding children and young people: roles and competencies for healthcare staff (January 2019).

The service had a safeguarding lead with level 4 adult and children safeguarding training. All staff we spoke with knew who the safeguarding lead was and how to contact them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All the staff we spoke with demonstrated they understood safeguarding processes and how to raise an alert. They could access support from senior staff if needed. Staff were aware of their responsibilities to protect vulnerable adults and children.

Staff had access to the safeguarding policy on the electronic shared drive. Information was also present on boards on the ward.

The service had an up to date chaperone policy. Staff were available for any patient requiring or requesting chaperoning.

Safety was promoted through recruitment procedures and employment checks. Staff had Disclosure and Barring Service (DBS) checks undertaken at the level appropriate to their role. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

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. Examination couches, chairs and pillows had wipeable covers and we saw disinfectant cleaning wipes being used to clean after every patient.

The service generally performed well for cleanliness. The service undertook a monthly infection control environmental audit to check compliance with the infection control and prevention policy. The audit results from June to September 2021 demonstrated compliance above the 95% target for all months.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. All areas were visibly clean and well maintained. Each area of the imaging department had a daily checklist for cleaning, and all were completed fully.

Staff followed infection control principles including the use of personal protective equipment (PPE). PPE, such as disposable gloves and aprons, were readily available for staff to use.

Hand washing posters were in several areas of the department, such as waiting room, hallways, boards, and treatment rooms, demonstrating best practice hand washing techniques. We observed staff were bare below the elbows even when not working clinically.Bare below the elbow national guidelines are for all staff working in healthcare environments to follow to reduce the risk of cross contamination between patients.

We reviewed hand hygiene audit results from April, June and August 2021, and compliance was consistently at 100%. The audit results were shared at the team meetings.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. In line with the government guidelines for Covid-19 the service performed enhanced and more frequent cleaning of surfaces to prevent transmission of the virus. This included increasing the frequency of cleaning of both the environment and equipment in patient areas, including frequently touched points and shared communal facilities.

Good

Diagnostic imaging

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 layout of the unit was compatible with health and building notification (HBN06) guidance. However, there was no direct access from the control area into the CT scanning room. In addition, the only access door could not be locked while the scanner was operational, this posed a risk of accidental radiation exposure if the door was opened. The CT scanner room could only be accessed by staff exiting the control area and entering via a secure corridor, in the event of an emergency this is not ideal. A radiation-controlled area light did however illuminate to indicate the scanner was operational to warn staff to not enter.

The service had suitable facilities to meet the needs of patients' families. The imaging department was located on the first floor. The reception area provided ample waiting area and toilet facilities for patients and their relatives. There was also a board introducing the team, and patient feedback forms were available.

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

There was sufficient space for staff to move around the scanner and for scans to be carried out safely. During scanning, all patients had access to a panic alarm button, ear plugs and ear defenders. Patients could have music played whilst being scanned. There was a microphone which allowed contact between the radiographer and the patient at all times.

In accordance with MHRA guidance, the MRI room was equipped with oxygen monitors to ensure that any gas leaking, for example liquid nitrogen or liquid helium would be identified. This ensured that oxygen levels remained safe not compromising patient safety.

An MRI safe wheelchair and trolley were available for patients in the event that they would need to be transferred from the scanner in an emergency.Unauthorised access was restricted. We saw warning signs and lights in use on the day of our inspection, all areas were monitored and had oversight from the reception staff.

All relevant equipment in the MRI unit was labelled in accordance with MHRA recommendations. For example, “MR Safe” or “MR Unsafe” to indicate that these pieces of equipment were safe or unsafe to use in an MR environment as per the MHRA safety guidelines for magnetic resonance imaging equipment.

The x-ray room was accessed off the main reception. The room where radiation exposure took place was clearly marked with warning signs and lights.

Lead screens were in place to protect staff from radiation. These were checked on an annually basis by the service’s medical physics expert.

Lead aprons were available for use if required and were subject to regular integrity checks by the service’s medical physics expert.

All equipment conformed to relevant safety standards and was regularly serviced. All non-medical electrical equipment was electrical safety tested.

Good

Diagnostic imaging

There were systems in place to ensure repairs to machines or equipment were completed and that repairs were timely. This ensured patients would not experience prolonged delays to their care and treatment due to equipment being broken and out of use.

Servicing and maintenance of premises and equipment was carried out using a planned preventative maintenance programme.

During our inspection we checked the service dates for equipment, including scanners. All the equipment we checked was within the service date. The generators were also tested monthly on a planned schedule to ensure patient scanning was not affected.

Scales for weighing patients in the MRI unit had calibration stickers following service. Resuscitation equipment was available in the imaging department located in the hallway. This was shared with the outpatients department. The resuscitation equipment was visibly clean, serviced and tagged to indicate whether equipment had been tampered with.

Staff carried out daily resuscitation equipment checks. We reviewed the records for resuscitation equipment checks from July to September 2021, and these were completed accordingly.

Staff disposed of clinical waste safely. Waste was handled and disposed of in a way that kept people safe. Staff used the correct system to handle and sort different types of waste and these were labelled appropriately.

Sharps management complied with Health and Safety and the Sharp Instruments in Healthcare Regulations 2013. We saw sharps containers were used appropriately and they were dated and signed when brought into use.

Assessing and responding to patient risk

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

Staff completed risk assessments for each patient on arrival, using a recognised tool. For example, the service used a magnetic resonance imaging (MRI) patient safety questionnaire. Risks were managed and updated in line with any change in the patient's condition. Patients referrals were checked at the point of referral for any potential safety alerts that required further investigation.

Processes were in place to ensure the correct patient received the correct radiological scan at the right time. The service did have a Society of Radiographers (SoR) 'pause and check' poster within the unit. The posters were used as a reminder for staff to carry out checks on patients.

We saw staff checking three-points of demographic checks to correctly identify the patient. Completing the 'pause and check' provides assurance that the radiographer used the correct imaging modality, the correct patient and correct part of the body was scanned. Using the 'pause and check' also decreases the number of wrong site scans.

In the event of an emergency, there were procedures in place for removal of a collapsed patient from the MRI scanner. Staff told us of a practice evacuation of a patient from the MRI in the last 12 months. Staff were confident in their explanation of what they would do in the event of having to remove a patient from the scanner in an emergency.

Good

Diagnostic imaging

Staff responded promptly to any sudden deterioration in a patient's health. There were processes for staff with regards to people using the service who became unexpectedly unwell or if an unexpected result was found during the scan. If a patient required urgent treatment staff told us they would call 999 for an emergency transfer to the local hospital. However, we did not see a procedure for admissions of deteriorating patients to the NHS.

All staff completed adult basic life support (BLS) training. At the time of our inspection 81% of staff were compliant with adult BLS training.

The service had a nominated radiation protection supervisor (RPS) in post. The RPS ensured compliance with the Ionising Radiations Regulations 2017 (IRR17) in respect of work carried out in an area which is subject to Local Rules.

Local rules were in place to ensure the health and safety of patients and staff in areas where ionising radiation was in use. Details of the RPS and RPA were included in the local rules, which was in line with the Ionising Radiations Regulations 2017 (IRR 17).

Clear signage was in place to warn patients of areas where radiation exposure took place, therefore limiting risk of accidental exposure.

Each imaging area contained an emergency alarm cord in the event of emergency or patient collapse.

Child-bearing status was routinely checked prior to any imaging taking place. Staff confirmed the patients' name, date of birth and address, confirmation of child-bearing status, and also ensured the patient had read information on procedure to be carried out. We saw these checks being carried out on the day of our inspection. Additionally, the questionnaire was gender neutral, which made it inclusive and accessible to transgender and non-binary patients.

Staffing

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

The service had enough staff to keep patients safe. Staffing levels were planned and reviewed in advance to ensure that an adequate number of suitably trained staff were available for each clinic.

The manager could adjust staffing levels daily according to the needs of patients.

The service had low vacancy rate. Staff told us there was a good ongoing recruitment drive, at the time of our inspection there was one vacancy for a Senior Radiographer.

The service had reported no sickness for clinical staff from July to September 2021.

Staff had access to a medical physics expert in the event of advice being required regarding diagnostic reference levels (DRLs). DRLs are a tool to optimise levels of radiation.

Medical staffing

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

Good

Diagnostic imaging

The service had enough medical staff to keep patients safe. There was a resident medical officer (RMO), with the relevant experience on site 24 hours, seven days a week with on-call access to patients’ consultants during evening and weekends. The RMO told us the consultants were easy to contact, responsive to requests and they felt valued by staff asking their opinion too. The RMO was trained in advanced life support and held a bleep for immediate response, for example, in the case of cardiac arrest. Nursing staff told us the RMOs were approachable and responsive when required.

Records

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

Patient notes were comprehensive, and all staff could access them easily. Patients completed a safety consent checklist form consisting of the patients’ answers to safety screening questions and also recorded the patients’ consent to care and treatment. This was later scanned onto the electronic system and kept with the patients’ electronic records.

Records were stored securely. Patients’ personal data and information were kept secure. Only authorised staff had access to patients’ personal information. Staff training on information governance was part of the mandatory training.

Prior to completing a scan, staff confirmed that the patient had consented. Once the scan was completed, staff submitted the images to a radiologist for reporting.

We reviewed 10 patient records during our inspection and saw records were accurate, complete, legible and up to date.

The service provided electronic access to diagnostic results and could share information electronically if referring a patient to a hospital.

The service used radiology information system (RIS), picture archiving and a communication system (PACS) to load the images for the scans and for radiologists to report and transfer to the referring clinician. Both these systems were secure, and password protected. Each member of staff had their own password to access the information system.

The service had an up-to-date policy for records management and information life-cycle. The policy provided staff clear guidance on the storage, retention period and destruction of records according to current information and data protection guidance.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff followed current national practice to check patients had the correct medicines.

We reviewed Patient Group Directions (PGDs) and found them to be compliant. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. The service also used Patient Specific Directions (PSDs). PSDs are written instructions, signed by a doctor, dentist, or non-medical prescriber for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis. These were also compliant.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Good

Diagnostic imaging

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Staff labelled contrast with the date it entered the warming cabinet, this was monitored and disposed of after 28 days, this was in line with the manufacturers' guidance.

Incidents

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

Staff knew what incidents to report and how to report them. Staff understood their responsibilities to raise concerns, to record safety incidents, and investigate and record near misses. Staff reported incidents using an electronic reporting system.

Staff reported serious incidents clearly and in line with provider policy. An up-to-date incident reporting policy and procedure was in place to guide staff in the process of reporting incidents.

There were no never events reported for the service from August 2020 to September 2021. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

In 12 months prior to our inspection, there were no serious incidents reported for the service. Serious incidents are events in health care where there is potential for learning, or the consequences are so significant that they warrant using additional resources to mount a comprehensive response.

The service reported five incidents from June 2021 to September 2021. These incidents were sub-categorised as cancellation, delayed waiting time and documentation error.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff we spoke with could tell us their understanding of the requirements of the duty of candour regulation.

Staff received feedback from investigation of incidents, both internal and external to the service. Learning from incidents was shared with staff at daily safety huddle, team meetings, and by email.

Staff used a specific form to record and report radiation doses greater than the intended dose. The service had a named radiation protection advisor (RPA) who would review any incidents relating to radiation. There had been no radiation incidents in the 12 months prior to our inspection.

Are Diagnostic imaging effective?

Inspected but not rated

In accordance with our current methodology we do not rate effective in Diagnostic Imaging.

Good

Diagnostic imaging

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

We reviewed policies, procedures and guidelines information, which referenced guidance from professional organisations such as the National Institute for Health and Care Excellence (NICE), Medicines, the Healthcare Products Regulatory Agency (MHRA) and the Department of Health (DoH).

The computerised tomography (CT) scan procedures were out of date (March 2020). However, the service has since confirmed a review of the scan procedures has taken place and the date for the next review has been updated.

Patients care and treatment was delivered, and clinical outcomes monitored in accordance with guidance from the National Institute for Health and Care Excellence (NICE). NICE guidance was followed for diagnostic imaging pathways as part of specific clinical conditions.

The service had local rules based on national guidelines. We found the local rules provided clear guidance on areas relating to hazards and safety and the responsibilities of staff to ensure work was carried out in accordance with the local rules. The MRI and X-ray unit had its own local rules with a suitable review date. All local rules were all in date. However, in some areas paper copies of documents were not the most recent versions. We raised this with the provider and obtained reassurance the policies would be reviewed and updated.

Local audits were completed monthly, quarterly and annually to assess clinical practice in accordance with local and national guidance. Areas audited were infection and prevention control, patient experience, waiting times, image quality assurance and quality of referral form.

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

Nutrition and hydration

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

Staff made sure patients had enough to drink. There was fresh water and hot drinks were available on request. Guidance was given on fasting in information given to the patient in advance. Radiographers checked this guidance had been followed when speaking with patients.

Pain relief

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

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

Good

Diagnostic imaging

All patients attended as an outpatient or from a ward. Staff assessed patients' pain both before and during imaging procedures. Patients attending from home were advised to bring any medication with them they might require during their attendance. Inpatients would be returned to wards as a priority if their pain was not controlled for pain relief to be administered.

Patients received pain relief soon after requesting it. We saw staff frequently asking patients if they were comfortable during their procedure. Cold patches were available where needed.

Patient outcomes

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

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. An annual local audit plan was in place and used to drive service improvements. Some of the areas audited included radiation protection supervisor (RPS) reports, pause and check, rejected images, quality assurance and radiation badge. The results of these audits and any issues that were identified were fed back to the radiologists and radiographers and the service used it for quality assurance purposes and learning and improvement.

Managers shared and made sure staff understood information from the audits. The service participated in the hospital's audit programme which demonstrated compliance and identified areas for improvements to improve patient care, treatment and outcomes. Results from audits were monitored and discussed at the hospital's clinical governance and medical advisory committees on a monthly basis as well as at a regional and corporate level. If actions were required, this would be fed back to the departments.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff skills were assessed as part of the recruitment process, at induction, through the probation period and then ongoing as part of the continuous professional development (CPD) process. We found that 38% of the Diagnostic and Imaging department also held Post Graduate Training MRI Certificates.

Managers gave all new staff a full induction tailored to their role before they started work. All staff received a local and corporate induction and completed an initial competency assessment. Staff we spoke with told us the local induction provided assurance that staff were competent to perform their required role. For clinical staff, this was supported by a comprehensive competency assessment toolkit. This covered key areas applicable across different staff roles including equipment and clinical competency skills relevant to their role and experience.

Managers supported staff to develop through yearly, constructive appraisals of their work. Data provided by the service showed that 80% of staff had completed an appraisal in the last 12 months prior to the inspection. This was in line with the internal target.

Performance of radiographers was monitored through peer review and quality audit. Any issues were discussed in a supportive environment. Radiologists fed back any performance issues with scanning to enhance learning or highlight areas of improvement in individual radiographers' performance.

Good

Diagnostic imaging

All radiographers employed by the service were registered with the Health and Care Professions Council (HCPC) and met HCPC regulatory standards to ensure the delivery of safe and effective services to patients.

Multidisciplinary working

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

Staff told us that they worked closely with other providers who referred patients to their service to provide a seamless treatment pathway for patients.

Staff told us there was good communication between services and there were opportunities for them to contact other providers for advice, support and clarification.

The service had systems and processes in place to communicate and refer to the local hospitals or the referring clinician in the event of further examination and or treatment being required. We saw evidence that reports to other healthcare professional took place in a timely manner.

Seven-day services

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

Appointments were flexible to meet the needs of patients, and appointments were available at short notice. We were told that a senior manager was available in an on-call capacity out of usual office working hours.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas.

The hospital used laminated health promoting posters relating to COVID-19 in public areas. These reminded patients of the importance of social distancing and washing hands to reduce the risk of transmission of the virus.

Information leaflets were provided for patients on what the scan would entail and what was expected of them prior to a scan. The service also provided information to patients on self-care following a scan.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. All staff we spoke with understood the requirements of the Mental Capacity Act 2005. Staff complete an eLearning course on the Mental Capacity Act as part of the mandatory training module.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We reviewed 10 patient records which demonstrated that written documented consent was obtained prior to the patient’s procedure.

Good

Diagnostic imaging

Staff made sure patients consented to treatment based on all the information available. All staff we spoke with were clear in their responsibilities with obtaining and documenting consent.

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

Are Diagnostic imaging caring?

Good

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff treating patients with dignity, courtesy and respect. We observed that staff introduced themselves prior to the start of a patient's imaging scan, interacted well with patients and included them during general conversation.

Patients said staff treated them well and with kindness. Patients we spoke with described staff as caring and kind. We also reviewed 14 thank you cards, reflecting very positive feedback from patients from the past 12 months.

Staff ensured that patients' privacy and dignity was maintained during their time in the diagnostic centre and during scanning. Patients had designated changing rooms and were provided with a gown if required in the changing room. Staff ensured patients were covered as much as possible during procedures to preserve their modesty and dignity.

Patient feedback was captured through the friends and family test (FFT) survey. Details on how to give feedback was displayed on notice boards throughout the clinic. Managers told us that patient feedback was reviewed monthly and shared with at staff meetings. Any dissatisfied patients, if they left their contact details, would be contacted and resolve the issues raised. We reviewed patient feedback from March 2020 to August 2021 and noted 93% of this was positive.

Patient feedback was consistently positive. We reviewed the patient experience friends and family test (FFT) from March 2020 to August 2021, where 93% of patients responded that they had a very good or good experience of the service. Staff told us negative comments were scrutinised for opportunities to drive improvement in the service which included changes to premises, staff training or patient information.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff supported people through their scans, ensuring they were well informed and knew what to expect.

Good

Diagnostic imaging

Staff provided reassurance and support for nervous, anxious, and claustrophobic patients. They demonstrated a calm and reassuring attitude so as not to increase patients' anxiety.

We observed staff provide ongoing reassurance throughout the MRI scan, they updated the patient on how long they had been in the scanner and how long was left. Patients also had a panic button they could press any time during the scan to summon help. Staff could stop the scanning immediately if the patient requested this.

We reviewed patient feedback from January to June 2021, and comments included, "put me at ease and explained everything they were going to do", "I felt very welcome which made me more at ease", "staff were professional and efficient, whilst still being friendly and helpful", "kind and reassuring", "staff were fantastic, made you feel at ease".

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.

We saw staff making patients as comfortable as possible. They ensured the patient was in control throughout the scan and gave them an emergency call buzzer to allow them to communicate with staff if they needed to. The MRI scanner had built in microphones to enable a two-way conversation.

We saw patients being advised should they wish to stop their examination, staff then assisted them and discussed choices for further imaging or different techniques and coping mechanisms to complete the procedures.

Staff made sure patients and those close to them understood their care and procedures. Staff recognised when patients and those close to them needed additional support to help them understand and be involved in their care and treatment and enabled them to access this. This included, for example, using to interpreting and translation services.

We observed that staff answered patients' questions appropriately, and in a way they could understand. Staff explained to patients how and when the results would be sent to the referring clinician.

The service allowed for a parent or family member or carer to remain with the patient for their scan if this was necessary.

Patients and their families could give feedback on the service and their treatment. Throughout the service posters were displayed on how to give feedback and patients and their families could also give feedback electronically.

Patients gave positive feedback about the service. Friends and family test (FFT) from March 2020 to August 2021 showed 93% of patients responded that they had a very good or good experience of the service.

Are Diagnostic imaging responsive?

Good

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

Good

Diagnostic imaging

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 local population. The service provided evening and weekend appointments to accommodate the needs of patients who were unable to attend during the day on weekdays.

Facilities and premises were appropriate for the services being delivered. Patients were greeted when they entered the service and accessed a comfortable waiting area, there were toilet facilities available for people to use.

There were adequate seating areas within the service, it was well lit and patients and visitors had access to refreshments. Waiting areas were designed to provide a calm environment to make the patient visit as relaxing as possible.

There were ample free car parking facilities for patients to use with designated disabled parking.

The service's website gave people useful information about the service it provided, its other clinic sites and the referral processes.

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 and all areas within the service were accessible to wheelchair users. This included level access from the car park set down area and automatic entry doors at the main entry as well as entrances to the diagnostic imaging department.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff were able to give examples of when these documents had been used to support patients.

The service had information leaflets available in languages spoken by the patients and local community.

A range of diagnostic and imaging related leaflets were available to patients. Patients could also access information on MRI scanning and the different types of diagnostic imaging modalities from the BMI the Hampshire Clinic website.

An interpreting service was available for patients whose first language was not English. All staff we spoke to showed good knowledge and awareness of the service and knew who to contact if required.

The service had arrangements to meet the needs of those with sensory impairment. Hearing loops were available in the service, which helped those who used hearing aids to access services.

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.

Good

Diagnostic imaging

Managers monitored waiting times and made sure patients could access services when needed. People could access the service when they needed it. Patients were offered a choice of appointment and staff told us that there was no issue with providing appointments in timely way.

The average wait time for imaging across all modalities over the last 12 months was 3 days. The service did not have any patients waiting for diagnostic imaging appointment for more than 6 weeks. X-ray's was a walk-in service done on same day with no wait time. Ultrasound requests would be booked in with the preferred radiologists and can at times be done on the same day or within a week. Non urgent magnetic resonance imaging (MRI) scans were booked within a week and if urgent on the same day.

Managers worked to keep the number of cancelled appointments to a minimum. In the last six months the service had six cancelled appointments. Reasons for cancellation were varied, including equipment break down, miscommunication around costs and wrong referral forms.

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. All the patients we spoke with knew how to make a complaint or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

The service reported they had received five complaints between March and August 2021. The complaints were investigated and responded to in line with the policy. We saw evidence of the changes implemented as a result of the complaint whereby the imaging referral form was updated to make it clear to patients the type of diagnostic tests being requested and the potential charges.

Staff understood the policy on complaints and knew how to handle them. The service had an up to date concerns and complaints management policy. Staff we spoke with explained how complaints were managed, the responses included an apology to the patient, any lessons learnt from the complaint shared and actions implemented.

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning from complaints was communicated to staff through staff meetings and emails.

Are Diagnostic imaging well-led?

Good

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

Leadership

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

Good

Diagnostic imaging

The hospital had a clear management structure in place with defined lines of responsibility and accountability.

The hospital was led by a senior management team consisting of an executive director (ED), a director of clinical services, a quality and risk manager and an operations manager.

The service had a national lead for diagnostic imaging, a clinical services manager for Imaging, who was also the infection prevention control link and radiation protection supervisor, a lead radiographer specialised in CT and MRI, and a deputy clinical services manager, who was also the health and safety representative. Further, there were seven contractual senior radiographers, and six bank radiographers.

All staff we spoke with told us they had a good relationship with their managers, and they felt supported in their roles, and able to access additional training and courses for professional development.

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.

Following the recommendations of the Francis report the ability for Radiologists to improve the standard of the service provided to patients by using a process of learning, self-reflection and personal development is imperative.

Real meetings (Realm) have been outlined by the Royal College of Radiologists (RCR) as a way of improving the standard of reporting by actively promoting a culture of shared learning without the pressure of blame. The RCR has updated their processes and formulated a document entitled Standards for radiology events and learning meetings document by the RCR (2020). The service had a detailed action plan to ensure these standards are consistently met and exceeded.

We also reviewed the service's vision and strategy document, mainly focused on providing effective and responsive care, ensuring a safe environment, and a caring and trustworthy culture. The main objectives laid out are prioritising in people, preserving safety, efficient practice, promoting professionalism and trust.

Culture

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

Staff were consistently positive when describing the culture within the service. They felt supported by all leaders and colleagues within the service. Staff felt respected and valued. All staff we spoke with were happy in their role and stated the service was a good place to work.

During our inspection we saw that staff interacted and engaged with each other in a polite, positive and supportive manner.

The service promoted equality and diversity and it was part of mandatory training. Managers and staff promoted inclusive and non-discriminatory practices. The provider had committed to meeting racial equality standards and had completed a WRES (Workforce Race Equality Standard) report for 2019 and 2020.

Good

Diagnostic imaging

A whistleblowing policy, duty of candour policy and appointment of freedom to speak up guardians supported staff to be open and honest.

There was good communication in the service from both local managers and at corporate level. Staff stated they were kept informed by various means, such as newsletters, team meetings and emails.

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.

We viewed a number of policies that the service had in place including; consent policy, incident reporting policy, infection prevention and control policy, concerns and complaints management policy, adult safeguarding policy and chaperone policy. All the policies had implementation and review dates, they contained references from national bodies such as the National Institute for Health and Care Excellence (NICE).

The service operated a clinical governance and assurance framework which aimed to assure the quality of services provided. At board level quality monitoring was through the clinical governance and safety committee.

Monthly safety, quality and risk committee meetings were held which included clinical assurance directors, medical directors and head of risk across the BMI Imaging sites.

The service also had a diagnostic imaging group meeting which consisted of the diagnostic manager, radiation protection supervisor (RPS), national clinical specialist for imaging.

Staff told us they were not aware of the location of the most up to date policies and procedures, although they told us they knew these had been recently amended. The service has since confirmed that these policies and procedures are stored on the intranet and a reminder has been sent to all staff.

Management of risk, issues and performance

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

Performance was monitored at local and corporate level.

The performance dashboard scorecard was updated and reviewed monthly by managers. The dashboard recorded report turn around, pause and check audit, WHO observational checklist, quality of referral form and post examination documentation and patient experience.

Medical physics and radiation protection advice (RPA) were provided by service level agreement (SLA) with a radiation protection advisor (RPA) from an external NHS trust. The RPA report dated March 2021 found no major concerns.

Good

Diagnostic imaging

Staff we spoke with were aware of the risk recording tool used by the hospital. They were able to give us examples of using it to highlight risks. However, there was no risk evaluation system at departmental level. Staff we spoke with were not aware of a diagnostic imaging risk register or of another risk measurement system. We highlighted this to the provider and obtained reassurance that a risk register for the department would be implemented as a matter of urgency.

Information Management

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

The service ensured data or notifications were sent to external bodies as and when required. We saw evidence that notifications such as serious incidents were submitted to regulators. Policies and procedures and data about performance were stored electronically and in paper format that staff easily accessed although some paper documents were out of date.

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems. There were effective technology systems to monitor and improve the quality of care. Access to information systems was restricted to only those who needed it, and this kept patient and confidential information secure.

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.

Leaders collaborated with partner organisations to help improve services for patients. They had a good working relationship with the local acute NHS trust. Additionally, staff gave us examples of supporting the local acute NHS Trust during the height of the pandemic.

We reviewed the Workforce Race Equality Standard submission for 2020 and the equality, diversity and human rights policy, both demonstrating that leaders are committed to driving equality.

Leaders engaged with staff using a variety of methods, including; annual staff surveys, team meetings, electronic communication, newsletters, staff notice boards and informal discussions. Staff felt their view and opinions were listened to.

The service engaged with patients and sought feedback to improve the quality of the services provided. Patient feedback forms provided areas of open text for qualitative information. Patient feedback was displayed and shared with the team and used to improve the service.

Staff knew how to support patients to give feedback and raise concerns. They had developed gender neutral child-bearing questionnaires, as well as prompts reminding reception staff to check pronouns to support LBGTQ+ patients.

Good

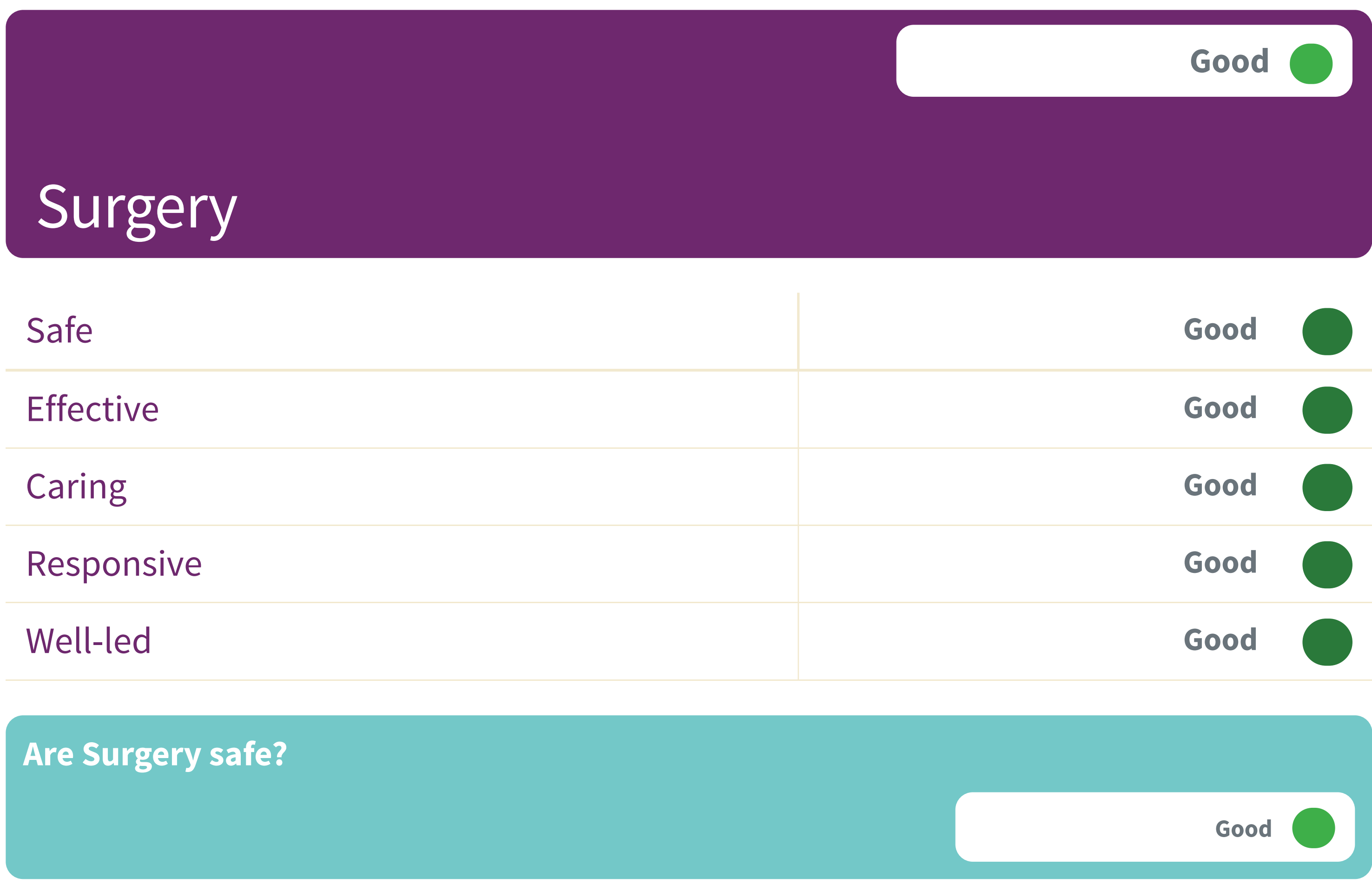
Diagnostic imaging

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.

We saw noticeboards that displayed comments from patients and staff, and actions the service had taken to improve services.

The diagnostic imaging department offered apprenticeships and training opportunities which helped to develop the skills and offered career progression to individuals in the team. In addition, it meant the service could grow their own talent which helped with staff retention.



Surgery

Good

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

Are Surgery safe?

Good

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

Mandatory training

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

Staff received and kept up to date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. The hospital followed the BMI Circle Health Group mandatory training policy which defined the mandatory training requirements of staff including bank workers. Mandatory training was split into departments and job roles. Staff working in the surgery service had a personalised list of mandatory training for them to complete.

Managers monitored mandatory training and alerted staff when they needed to update their training. Overall staff compliance with mandatory training was 94.08% for September 2021 which met the provider's compliance target of 90%.

Staff told us they felt supported by their managers but said it could be difficult to find time to complete some training. There had been challenges where some face-to-face training was cancelled due to the COVID-19 pandemic and had to be rescheduled. We were told this was improving and at the time of our inspection, face-to-face training had restarted, and staff were catching up on the training that had been delayed.

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.

The hospital followed the BMI Circle Health Group safeguarding adults and safeguarding children and young people policies. These policies provided staff with guidance on how to identify abuse and the processes to follow if needing to raise a safeguarding concern. These policies covered other elements of safeguarding such as radicalisation and female genital mutilation.

Staff received training specific for their role on how to recognise and report abuse. They were clear about the hospital's safeguarding escalation process. Safeguarding information, including contact details for the safeguarding lead was displayed in the ward.

The lead for adult safeguarding was the director of clinical services. Staff told us the safeguarding lead was accessible and responsive. Staff had received safeguarding training at the correct levels for their roles.

Safeguarding adults training figures provided to us showed 93.2% of staff had completed safeguarding level two training. Staff had PREVENT training and 94.1% of those eligible had completed it.

Consultants undertook their safeguarding training at the substantive NHS hospital and were expected to provide evidence of this training.

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.

BMI The Hampshire Clinic had infection control policies and procedures to help control infection risk. These and other related policies covered the actions required by staff to minimise the risk of infection and cross infection in the hospital and the surgery service. In addition, new protocols and procedures had been produced in response to the COVID-19 pandemic. This included a new procedure for when staff, patients and visitors arrived at the hospital, and for patients who needed to home isolate and have a negative COVID-19 test prior to their elective surgery.

Staff could explain the procedures they would follow if they had concerns about a patient or visitor's infection status.

All staff completed twice weekly lateral flow testing and records of these were maintained. The vaccination status of all staff was recorded in their personnel records.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. The service performed well for cleanliness with overall positive feedback from patient satisfaction surveys. Audits showed there was good standard of cleanliness on the surgical ward.

We checked a theatre storeroom and found it to be visibly dirty. There did not appear to be a cleaning schedule for the room, so we could not be assured who was responsible for cleaning or when it had been last cleaned. We highlighted this to the hospital infection control lead who arranged an immediate clean of the room. It was also identified the room did not appear on the hospital cleaning schedule. The infection control lead immediately rectified the situation.

The service had begun a program of environmental improvements and refurbishments on both the wards and in theatres and was compliant with Health Building Note (HBN) 00-09. There were handwashing basins in all patient rooms and in the sluice room in theatres. The service identified some areas in the hospital where flooring work was still needed, including the waiting area for walk-in patients for theatre. This risk was monitored through the hospital governance processes, with an action plan in place.

The hospital was testing for legionella in the ensuite bathrooms in patient rooms. They had some positive results and were continuing to manage through water safety action plans, which included an on-going testing regime. There was also a plan in place for environmental updates and this was being managed through the hospital IPC and governance process.

Good

Surgery

Staff followed infection control principles including the use of personal protective equipment (PPE) and were observed to be bare below the elbow. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. The service audited every other month for infection prevention and control and hand hygiene and performed well with compliance averaging 100% over the last three audits.

Staff worked effectively to prevent, identify and treat surgical site infections. As a result of the Covid-19 pandemic, the service ensured all patients were tested for Covid-19 prior to their admission. The service ensured patients for joint surgery had swabs for Methicillin-resistant Staphylococcus aureus (MRSA) and Methicillin-sensitive Staphylococcus aureus (MSSA).

The service used an external contractor for decontamination of instruments off-site and for deep cleans of theatres. There was a service level agreement for the provision of microbiology between the hospital and a local NHS trust. Audits showed deep cleans took place at regular intervals.

Environment and equipment

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

The service had suitable facilities to meet the needs of patients and enough suitable equipment to help them to safely care for patients. There were four theatre suites, three of which had laminar flow to help reduce the incidence of surgical site infections. At the time of the inspection one theatre was undergoing planned refurbishment and we were unable to access it.

Access to the theatre suites was restricted to authorised staff, with access by electronic swipe card/fob.

Each theatre had a preparation and attached anaesthetic room. The theatres were bright appeared clean and were in a good state of repair. However, in one theatre we noted a broken light in the main light cluster which, although working, it was held together by tape. There was a risk the light could stop working or the tape could fail during an operation. We highlighted this to the provider after the inspection. The service was aware and had completed a risk assessment for the broken light. They had instigated regular review of the risk and we saw evidence of a replacement programme in place for all theatre lights.

Within a theatre storeroom were switches for gases used in theatres. The glass panel protecting one of the switches was broken. Staff were unsure which theatre the switches serviced. The box with the broken glass was visibly dusty and dirty. There was an infection control risk and a risk that someone could injure themselves on the broken glass. We highlighted this to the service during the inspection. Steps were taken at once to make safe and secure the broken glass, and then obtain a replacement piece.

The recovery area contained six patient bays and were all equipped in line with Association of Anaesthetics of Great Britain and Ireland (AAGBI) and British Anaesthetic and Recovery Nurses Association (BARNA) recommendations, such as oxygen suction wave monitoring systems. The sluice in the recovery area was cluttered and we noted open bottles of cleaning solutions behind the sink. We notified the service after the inspection and they rectified the situation and changed their practice with storage of such products.

Good

Surgery

Staff carried out daily safety checks of specialist equipment. For example, anaesthetists checked the anaesthetic machine, and the logbook was signed, dated and the number of breathing circuits were recorded. We looked at the resuscitation trolleys and found equipment was available, ready for use and had been checked regularly. Medical equipment in theatres and on the wards, we inspected had stickers to indicate they had been serviced and maintained and were in date.

The theatre suite had a difficult airways trolley which was checked weekly. Records we reviewed during our inspection showed all equipment checks were carried out meaning there was a consistent and regular approach to safety checks.

There were three wards, all with single rooms. All rooms were en suite, had been refurbished, and included wet rooms. Some patient rooms had been repurposed during the COVID pandemic as offices. This allowed staff to maintain social distancing. In addition, rooms previously used for paediatric patients were being refurbished and therefore not in use at the time of the inspection.

Patients could reach call bells and staff responded quickly when called. There were emergency call pulls in each patient room and easily accessible resuscitation trolleys for staff to use in the case of an emergency. Staff checked the resuscitation trolleys daily to ensure equipment there was sufficient equipment and that it was in good working order.

Staff disposed of clinical waste safely. Hazardous waste was placed in the appropriate disposal bins and sharps bins were not overfull. However, in recovery we saw an open sharps bin, without a lid, being used as a general waste bin. This posed infection control and injury risks to staff using that area.

Assessing and responding to patient risk

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

The hospital had an admission criteria which meant the hospital only admitted patients whom the hospital had facilities to care for. Patients with complex co-morbidity and bariatric patients would not routinely be admitted for treatment. Admission exceptions were only considered on the presentation of all relevant clinical evidence, a risk assessment and the mitigation of risk and with the agreement from all parties involved in the care of the patient.

From observation in theatres, we found the service had processes in place to keep people safe and used the World Health Organisation (WHO) safety checklist for surgery. The WHO checklist is a nationally recognised system of checks designed to prevent avoidable harm and mistakes during surgical procedures. We observed the process was embedded and checklists were completed in accordance with BMI policy.

Staff shared key information to keep patients safe when handing over their care to others. We observed patient handovers to the recovery area and the procedure followed the Association of Anaesthetics of Great Britain and Ireland guidelines, namely the procedure, anaesthetic drugs used, and the patient's co-morbidities were listed and discussed between staff.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. They used the national early warning system (NEWS2) tool to identify deteriorating patients. Records we reviewed showed that NEWS2 scores were calculated correctly. Patients who scored a high number were referred to the Resident Medical Officer (RMO), anaesthetists or consultants. If staff had concerns at any point during patient care, they could escalate for urgent review by the RMO. There was a service level agreement with a local trust for the transfer of care of critically ill patients.

Shift changes and handovers included all necessary key information to keep patients safe. On the ward, shift changes and handovers included all necessary key information to keep patients safe. Staff of all levels knew their part to play identifying and responding to sepsis.

Staff knew about and dealt with any specific risk issues. The patient's health records included a surgical booklet with a range of risk assessments including falls, moving and handling, bed rail, pressure ulcer assessments. These were all completed, and any issues identified during these assessments had an action plan developed to mitigate the risk. The pre-admission checklists identified any communication needs such as requiring an interpreter to ensure individual patient needs were met.

Staff held a resuscitation meeting each morning where they discussed and agreed roles in the event of an emergency. The RMO was always assigned as the team leader. The hospital also undertook unannounced resuscitation scenarios carried out by an external company. Staff emergency reactions to scenario-based situations were tested and assessed.

All clinical staff were immediate life support (ILS) trained and the RMO who was on site 24 hours was advanced life support trained. We reviewed the latest ILS scenario report, from 30 July 2021, produced by the external training company. The report described how staff performed the ILS scenario to a high standard.

Patients who had concerns following discharge, including day surgery would be given information on how to contact the hospital to access advice. Included in their discharge information was a leaflet on monitoring surgical wounds for infection. This gave patients information on wound care when they went home, the signs and symptoms of an infection and who to call if there was a problem. Ward staff would routinely call patients 48 hours after discharge to check how the patient was recovering and this was recorded in the patient's records.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. The hospital used a corporate staffing tool that had the ability to plan and track the staffing activities of the day and therefore provide staffing to match. The ward manager could adjust staffing levels daily according to the needs of patients. The tool was used to determine staffing levels in advance. The number of nurses and healthcare assistants matched the planned numbers.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

Bank staff were used in theatres and at the time of inspection managers reported no agency staff were used. The service always had the right staff with the right skills for the day. The hospital used the BMI resource model in theatres which incorporated Association for Perioperative Practice (AfPP) guidelines for safer staffing. We observed and records showed theatre staffing met these recommendations. Senior theatre staff told us they reviewed their staffing daily to ensure the theatre list could go ahead.

Staffing across the wards and theatres was reviewed daily during the morning communication cell meeting by the executive director and director of clinical services to ensure allocation of resources met the clinical needs of patients.

Medical staffing

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

Each patient was admitted to the hospital under the care of a named consultant with the relevant experience in that area of medicine. Consultants led and delivered the surgical service at the hospital under practising privileges.

The service had processes in place for consultants applying for practising privileges at the hospital. The service had a medical advisory committee (MAC) for governance of doctors working in the service to ensure they continued to meet the standards to practice at the hospital. Practising privileges is a well-established process within independent healthcare, whereby a medical practitioner is granted permission to work in an independent hospital.

The service had enough medical staff to keep patients safe. There was a resident medical officer (RMO), with the relevant experience on site 24 hours, seven days a week with on-call access to patients' consultants during evenings and weekends. If there was an urgent need the consultant returned the hospital to review their patients. The RMO told us the consultants were easy to contact, responsive to requests and they felt valued by consultants asking their opinion too.

Consultants returned to review their patient's post-surgery and saw their patients daily. The RMO reviewed patients in the morning to assess their needs. Any concerns were reported to the consultant.

For patients who had had minor operations, the consultant provided a post-operative plan to the ward. The RMO would review the plan and carry out the care as outlined. For more major surgery, for example hip and knee operations, the consultant always reviewed the patient post-operatively. If a consultant was on leave, they would handover patient care plans to other consultants.

The RMO was trained in advanced life support and held a bleep for immediate response, for example, in the case of cardiac arrest. Nursing staff told us the RMOs were approachable and responsive when required.

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.

Patients admitted to the hospital for a procedure had a care record. This was a single and complete record in a booklet form, containing all information from when a patient had been booked in for a procedure until follow up care after discharge had finished. These records were used for every patient and were multidisciplinary, meaning each clinical team wrote in the same set of records, including the surgical team.

Records were stored securely in a locked room or in areas only accessible to authorised staff. When patients transferred to a new team, there were no reported delays in staff accessing their records. Staff requested records from medical records and reported they were supplied to them in a timely way.

Patient notes were comprehensive, and all staff told us they could access them easily. Patient records were predominantly paper based. We reviewed nine sets of records, which ranged from a variety of inpatient and day case procedures. All records we reviewed were legible with evidence of completed risk assessments. All surgical patient records we saw had a fully completed WHO check list, a discharge checklist and evidence a post-operative call 48 hours post the procedure had been made.

Theatre staff maintained a log of implants on their prosthetic's register to enable traceability if an incident occurred. Theatre personnel retained a sticker from each implant in the register as well as in the patient notes.

The discharge letter was sent to the patient and GP and included post-operative instructions. This ensured continuation of patient care.

Once patients had been discharged and no further follow up care was required, records would be retained and stored securely within the medical records department. This department had responsibility for filing, storing and maintaining an adequate medical record for patients treated.

Medicines

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

Staff followed the hospital's policies and procedures when prescribing, administering, recording and storing medicines. The hospital had on-site pharmacists who were responsible for the supply and top up of medicines used in the theatre area and inpatient wards. Nursing staff told us pharmacy staff provided a good service and were available and accessible when needed.

On the ward and in theatres, all medicines we checked were within date and stored appropriately. We found all controlled drugs were stored correctly in locked cupboards and fridge temperatures were correct and had been checked and logged daily.

The service had an onsite pharmacy with availability Monday to Saturday and processes in place to access the pharmacy out of hours. Records reviewed showed allergies were documented, prescriptions were signed for in line with the medication's management policy and antibiotics were prescribed as per guidelines and reviewed appropriately.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. A range of medicine audits were undertaken to ensure compliance with local and national guidance, with results discussed at the medicine management committee. Minutes from this committee indicated appropriate actions were taken where any issues were identified.

Medicines management was a regular slot at the clinical governance meeting and included any errors, near misses or medicine related matters. Medicine updates, including information related to controlled drugs was circulated to staff via the clinical governance meeting. More urgent messages were communicated straight away using the daily communication cell meeting attended by head of departments.

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.

All incidents were reported in line with the BMI Circle Health Group incident management policy. The policy included definitions of incidents and their level of harm and how incidents should be reported, investigated and actions taken.

Staff knew what incidents to report and how to report them using an electronic incident reporting system. They raised concerns and reported incidents and near misses in line with the provider's policy.

Good

Surgery

Incidents reported were discussed the following day at the daily communication cell meeting. A representative from each department was present at the meeting and this meant feedback and issues from incidents could be cascaded quickly. Staff told us they received feedback from investigations of incidents that had occurred both internally and other BMI hospitals.

We reviewed the records of four incidents. In all four we noted a full review of the cases had been carried out. Where appropriate, learning was identified, and relevant action plans were put in place. All cases had had their action plans completed.

No never events were reported in surgery in the six months prior to the inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

The service reported no hospital acquired surgical site infections in the six months prior to the inspection.

The service produced monthly quality and risk reports, and these were discussed in the clinical governance meetings. Incidents was a set agenda item within this meeting. Mortality and morbidity were a set agenda item in the medical advisory committee (MAC) monthly meetings.

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. We saw examples where duty of candour was discussed at clinical governance meetings.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The service continually monitored safety performance and data was displayed on wards for staff and patients to see. The hospital had a system to monitor pressure ulcers, falls, venous thromboembolism (VTE) and infection rates. For example, we saw evidence that falls incidents were discussed at clinical governance meetings with actions to ensure risk assessments were completed fully.

Staff used the data to further improve services. Staff displayed ‘You Said! We Did!’ information to demonstrate how they improved the service based on feedback from patients. For example, patients reported noisy clocks, so these were replaced. Patients requested more menu options, so a new menu was introduced.

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

Evidence-based care and treatment

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

Good

Surgery

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies and guidelines were developed in line with the Royal College of Surgeons, Royal College of Anaesthetists, and National Institute for Health and Care Excellence (NICE) guidelines.

Patients were assessed using the American Society of Anaesthesiologist (ASA) grading system for pre-operative health of surgical patients. This is a system to record the overall health status of a patient prior to surgery. The system enabled the staff and anaesthetists to plan specific post-operative care for patients as required.

Policies, NICE guidelines and national guidelines were a set agenda items on the clinical governance committee meetings and were monitored through the BMI clinical governance bulletin and hospital and clinical governance committee. We reviewed committee meeting minutes which demonstrated these items were discussed and reviewed.

Staff were able to access policies and local protocols via the hospital intranet, and ward portfolios. Throughout the inspection we found staff followed national guidance and adhered to corporate policies. All policies we sampled were regularly reviewed and included appropriate references to relevant national guidance.

A corporate clinical audit programme enabled the hospital to bench mark itself against other BMI hospitals within the BMI healthcare group. Audits undertaken included the World Health Organisation surgical safety checklist, infection prevention and medicines management.

Nutrition and hydration

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

Patients waiting for surgery were kept 'nil by mouth' in accordance with national safety guidance. Patients were advised about fasting times (not eating or drinking before surgery) during the pre-assessment process. The service followed the Royal College of Anaesthetists guidance about pre-operative fasting to ensure patients fasted for the safest minimal time possible.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff used the Malnutrition Universal Screening Tool (MUST) to assess patient's risk of malnutrition. Records we reviewed demonstrated staff had used the tool.

An external catering company provided all meals on the wards. There was a choice of meals available for patients, which included lighter options and full meals. On request the catering company provided meals which supported cultural and religious choices.

Patient satisfaction survey's June to August 2021 showed the hospital scored well for catering, with 89% of responses given as 'very good' or 'excellent'.

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 and gave pain relief in line with individual needs and best practice. Patients we spoke with said their pain was well-controlled and they received pain relief soon after requesting it.

Good

Surgery

Nursing staff discussed post-operative pain relief with patients as part of their pre-assessment and gave them written information as well to support these discussions. Pain management was part of the patient discharge process. Pharmacy and nursing staff would speak with patients about their pain medicines and gave clear instructions on its use at home.

Patients we spoke with said their pain was managed well and pain relief was available to them when they needed it.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under the Association for Perioperative Practice (AfPP).

The hospital had systems and processes in place to monitor, audit and benchmark the quality of services, and the outcomes for patients receiving care and treatment.

The service participated in relevant national clinical audits. The hospital submitted data to national audit programmes such as the national joint registry (NJR) to help improve patient safety. The service collected information on patient reported outcome measures (PROMs) for hip and knee replacements. PROMs use patient questionnaires to assess the quality of care and outcome measures following surgery.

The service submitted outcome data to the Private Healthcare Information Network (PHIN) and outcomes for patients were overall positive and met national standards. The service had an established and clear pathway for patients undergoing joint replacement to support their outcomes after surgery.

The service participated in the hospital's audit programme which demonstrated compliance and identified areas for improvements to improve patient care, treatment and outcomes. Results from audits were monitored and discussed at the hospital's clinical governance and medical advisory committees on a monthly basis as well as at a regional and corporate level. If actions were required, this would be fed back to the departments.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. This included specialist training for their role.

All new staff participated in an induction tailored to their role before they started work and were supported to develop through yearly appraisals of their work. As well as mandatory training staff completed scenario-based training sessions such as cardiac arrest.

The hospital had a practice educator who supported the learning and development needs of staff. Staff working in the surgery service talked highly of the support provided by the clinical educator since the role had been introduced. Staff described how they were able to access training courses to support their professional development. We saw details of upcoming training courses displayed on noticeboards. These were available to all staff to attend.

Good

Surgery

Managers identified poor staff performance promptly and supported staff to improve. Staff gave examples of where they had been supported to improve their practice. For example, following scenario-based training staff told us additional training had been put in place to improve skills and confidence.

Managers ensured staff had to time to attend team meetings or had access to full notes when they could not attend.

Multidisciplinary working

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

We observed effective collaborative multidisciplinary working across surgery. Patient bedside meetings were held each morning and was attended by the RMO, pharmacy, physiotherapist, and registered nurse where each patient care plan was discussed.

We observed patient handovers between clinicians, for example between the consultant and RMO, where detail of the patient's condition and well-being and any potential risks were discussed. They were informative and detailed meetings.

The theatre and ward staff worked well together to ensure patients received appropriate handovers along their pathway of care. To aid safe and effective handovers of care, between the ward, theatre staff used a written Situation, background, Assessment, Recommendation (SBAR) handover tool.

Staff told us consultants attended their patients on ward rounds and were easy to access for information.

Seven-day services

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

The hospital did not provide emergency care. All surgical patients followed the elective pathway and admissions were booked in advance

Staff could call for support from doctors and other disciplines, diagnostic tests, 24 hours a day, seven days a week. Support arrangements for patient care was offered through a combination of 'on-site' and 'on-call' arrangements.

Consultants and Anaesthetists working under BMI practising privileges were available for their own patients and contact with them was made through the various departments should the need arise. Consultants and Anaesthetists were required to confirm suitable cover arrangements if they were unavailable or on annual leave.

Consultants led daily ward rounds on all wards, including weekends. There was a daily on-call team which included a pharmacist, radiographers, theatre team, engineer and a senior manager.

The resident medical officer (RMO) provided 24 hours 7 days a week service on a week on / week off basis. All RMOs were selected to specifically manage a variety of patient caseloads. The RMO had completed the Advanced Life Support (ALS) course.

Allied health professionals including physiotherapy and radiology staff provided care and support out-of-hours. The pharmacy service was available during the day six days a week. Outside of these hours the RMO and nursing staff dispensed medications which had already been prescribed, with access to an on-call pharmacist as needed.

Good

Surgery

Health promotion

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

The service had relevant information promoting healthy lifestyles and support. This was provided to patients on a case by case basis, leaflets had been removed from the wards due to COVID infection control measures.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. The service supported patients to be as fit as possible for surgery. At pre-operative assessments patients were advised on weight management and smoking and additional support was provided if necessary.

For example, patients having joint surgery, such as for hip or knee replacement, would see a physiotherapist on a one to one basis with tailored information specific for the patient. Patients were given pre-operative and post-operative exercises and assessed for need of occupational therapy or support from social services.

The hospital used laminated health promoting posters relating to COVID-19 in public areas. These reminded patients of the importance of social distancing and washing hands to reduce the risk of transmission of the virus.

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.

There was a BMI Circle Health Group corporate consent for examination and treatment policy. This included the training required to take consent, whose responsibility it was to obtain consent and when to use implied, verbal and written consent.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff had access to the BMI policies regarding consent and understood their roles and responsibilities when gaining consent from patients. Staff described how they gained consent from patients for their care and treatment in line with legislation and guidance.

Consent forms we reviewed within the patients' records were fully completed and detailed the procedure planned and the risks and benefits of the procedure. The hospital consent forms complied with Department of Health guidance. The service had a two-stage consent process. Patients' records showed consent was reviewed on the day of their surgery as part of their pre- operative checklist.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards through the mandatory training program. Staff could describe and knew how to access policies and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

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

Good

Surgery

Compassionate care

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

Staff followed the service's privacy and dignity policy to keep patient care and treatment confidential. On inspection, we observed all care and treatment of patients was undertaken in a way to maintain the patient's dignity. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Staff within theatres were respectful to patient's privacy and dignity and made sure patients were covered with gowns or blankets when being transported or escorted to other areas within the hospital.

We observed care was given in a compassionate and dignified way. Staff were friendly, kind and treated patients with respect. Staff were discrete and ensured patient discussions on treatment took place in private consultation rooms. Patients told us staff were professional and had asked them throughout their care if they were comfortable.

We saw examples of thank you cards displayed throughout the wards with comments thanking the staff for their care and support during treatment.

The wards displayed patient satisfaction results. For the month of August 2021 results showed 99% of patients would recommend family and friends to the hospital. 98.2% of patients said they felt they were treated with dignity and respect at all times.

Emotional support

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

When talking with staff, it was clear how passionate they were about caring for their patients and how they put patients' needs at the forefront of everything they did.

The hospital had developed the role of Patient Advocate to provide support to patients, initially during the pandemic period, when patients could not have visitors. This had been developed from the actions of a staff member who had seen patients were alone and decided to provide a friendly face and someone they could talk too. A job description was drafted, and the role was piloted for 3 months with that same staff member. It had proven to be a success and it was hoped the role would be made permanent.

Staff gave patients and those close to them help, emotional support and advice when they needed it, for example supporting patients who experienced anxiety with surgical procedures. The service offered treatment plans in line with the patients' wishes. Staff gave examples where they had supported patients with learning difficulties to access care in a supportive way. This included involving the hospital dementia lead, providing one-to-one care and using a patient passport which described what the patient liked. All these resources helped to gain the trust of the patient on the day of their surgery.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their well-being and on those close to them. Staff told us they were mindful of their non-verbal communication with patients and how they could help patients feel more at ease through their interactions.

Good

Surgery

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.

We observed good interactions and relationships between staff and patients, which allowed positive informal discussions to take place. Patients told us they had been involved in all aspects of their care.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients could provide feedback in the hospital or at home; they gave positive feedback about the service overall. Patient satisfaction results for August 2021 showed 99% of patients would be likely or extremely likely to recommend the hospital.

The service had received several thank you cards, and some were displayed on the ward. Patients we spoke with were very positive about the staff, food, and outcomes of their care.

Staff communicated with patients about their care and treatment in a way they could understand. Patients told us staff were thorough when explaining what would happen and they had enough time to ask questions. Patient records showed discussions had taken place about the potential risk and complications of surgery, as well as the benefits and alternative treatment available. Staff supported patients to make informed decisions about their care.

Appointment times were flexible to accommodate individual patient needs. Time was given to go through all information including costs for those patients who were self-paying. NHS and non-NHS patients were not treated differently in any way.

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

Service delivery to meet the needs of local people

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

Managers planned and organised services to meet the needs of those who chose to use the service. Facilities and premises were appropriate for the services being delivered.

Admissions to the surgical service were all elective and planned in advance. The hospital had an admission criteria which meant the hospital only admitted patients whom the hospital had facilities to care for.

There were no facilities for emergency admissions; commissioners and the local NHS trust were aware of this. The hospital had service level agreements in place with the local NHS trust for transferring patients for medical reasons.

In response to the Covid-19 pandemic, the service had taken on some NHS work to support elective surgical services at a nearby local NHS trust. There was also a service level agreement to provide support to the cancer surgery service at the local NHS trust.

Good

Surgery

Meeting people's individual needs

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

The journey for surgical patients commenced with the pre-assessment process. Please see the Outpatient section for more details. Adjustments for patients were highlighted during the pre-assessment which meant this did not need to be repeated.

Surgical patients' individual needs were discussed during booking and pre-admission assessment. This information was used by staff to provide safe care and treatment and mitigate any possible risk to the patient. If during pre-admission assessment staff identified the service could not meet the patient's needs, staff would not treat the patient at the hospital and refer the patient to an alternative health care provider who could support the patient.

Staff gave us several examples of supporting patients with protected characteristics. Protected characteristics according to the Equality Act 2010 are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff were able to give examples of when these documents had been used to support patients. Wards were designed to meet the needs of patients living with dementia.

Staff had access to communication aids to help patients become partners in their care and treatment. Staff and patients could get help from interpreters or signers when needed. Staff would identify, at the time of booking appointments and treatment, if the patient required an interpreter. This meant interpreters support was planned for each part of the patient journey.

Patients with hearing or sight impairments were flagged during pre-operative assessment, which meant staff could ensure patients could access information according to their needs. Staff could provide leaflets in 'larger print'. An assistive listening device was available at reception to support patients with hearing impairment.

Patients could request a choice of food and drink to meet their cultural and religious preferences.

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.

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

The service did not have a waiting list as all surgery was elective and access to the service was flexible to meet patient's needs.

As part of a national contract to support the NHS during the COVID-19 pandemic, the service provided surgical services for NHS patients. Managers liaised with NHS colleagues to monitor and manage admissions. They had systems to monitor where they would not meet targets and made plans for patients to receive care as soon as possible.

Staff provided support to patients when they were referred or transferred between NHS and private services to ensure continuity of their care.

Should patients have had their operations cancelled at the last minute, either due to operational or clinical issues, managers made sure they were re-arranged as soon as possible.

Managers and staff started discharge planning as early as possible, ensuring patients did not stay longer than they needed to. Managers monitored the number of delayed discharges and took action to prevent them.

The hospital managed clinic capacity to ensure and maintain short wait times. Private patients were able to book appointments through a centralised team or website, which included a 'live chat' support function.

Learning from complaints and concerns

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

The hospital followed the BMI Circle Health Group complaints policy which gave clear processes and timeframes for dealing with complaints. The hospital's executive director had overall responsibility for the management of complaints.

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. We saw complaints were discussed during daily communication cells meetings.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to effectively manage them. This included reporting complaints through the electronic reporting system, acknowledging a complaint and how to escalate if necessary.

The service treated concerns and complaints seriously, investigated them and learnt lessons from the results. Managers aimed to resolve patient complaints at the point of care to improve the patient's experience. Patients and staff received feedback from managers once the complaint investigation had been concluded and the learning was used to improve the service.

The hospital received 36 complaints between March 2021 and August 2021. Complaints content varied from lack of communication to clinical care and treatment concerns. None of these complaints had been referred to the ombudsman or the Independent Healthcare Sector Complaints Adjudication Service (ISCAS) by the complainant.

We reviewed a sample of complaints and their responses. We saw complaints were reviewed in line with BMI policy and were thorough. All were complete, they focused on the concern highlighted and, where appropriate, opportunities for improvement where identified.

We reviewed minutes of various meetings and saw patient complaints were discussed in the local team meetings.

Are Surgery well-led?

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

Leadership

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

The hospital had a clear management structure in place with defined lines of responsibility and accountability.

The hospital was led by a senior management team consisting of an executive director (ED), a director of clinical services, a quality and risk manager and an operations manager. There were clinical services managers (CSMs) for both theatres and wards. The service also had a lead infection prevention and control (IPC) nurse and a clinical educator.

At the time of the inspection the director of clinical services role was interim and being filled by the CSM for theatres. Additional support for that role was provided by the regional management team as well as the hospital ED. The newly appointed director of clinical services was due to start their substantive role shortly after the inspection. The theatre CSM role was being backfilled by an experienced and long-standing member of theatre staff.

Staff told us their managers were very supportive and encouraged their career progression. All levels of staff told us the executives were visible, accessible and supportive. Leaders worked together to support and improve patient safety and patient experience.

Staff within theatres and the wards described being well supported by the CSMs. They told us they were available to offer guidance and staff said they could talk through any concerns they had. The CSMs had a good understanding on the departmental risks and challenges they faced. The CSMs said they received good support from their respective managers.

Vision and Strategy

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

There was no specific vision and strategy for surgical services, however the hospital had identified a vision, values and objectives.

- Vision:

Prioritising our patients and staff ensuring a safe environment, whilst preserving an effective and responsive service being well led by a professional, caring and trustworthy culture.

- Values:

"Coming together is a beginning, keeping together is progress, working together is success."

- Objectives:

Good

Surgery

Prioritising in people, preserve safety, practise efficiency, promote professionalism and trust.

The vision, values and objectives aligned with the Circle Operating System (COS), that had been launched in March 2021 to all BMI hospitals. The COS was described as an established methodology within the Circle group that empowered all staff to work together to be safe and effective.

The main focuses for the COS were:

- Engagement
- Performance
- Clinical Leadership
- Devolved Power
- Continuous Improvement Methods

During our inspection we saw the vision, values and objectives displayed on noticeboards. Staff described the positive impact they had seen from Circle involvement with the hospital and were feeling the benefits of the COS.

Culture

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

Staff we met were welcoming, helpful and friendly. Staff told us they worked in a supportive environment and we saw cooperative and appreciative relationships amongst staff of all grades.

Staff told they were able to speak up about concerns and were supported by managers to do this. The hospital had a freedom to speak up guardian to ensure staff could raise concerns in a safe and supportive way. A corporate level speak up guardian was accessible to the post holder at the hospital to provide support, and regular meetings were held with other role holders in the BMI group.

In the year leading up to the inspection a staff survey had been commissioned so leaders could listen and respond to staff feedback. The survey covered five key areas:

Fair Deal / My Company / My Manager / Wellbeing / Giving Something Back

Following the survey a hospital specific action plan was drafted, with key actions assigned at corporate level, to the executive director (ED) and to the senior management team (SMT). For example, the confidence in the leadership team was identified as requiring action. Actions identified, such as developing training and improving visibility of the SMT, were assigned to the ED. During the inspection staff described some of the improvements they had seen. For example, the improved visibility of the SMT.

The service had developed an apprenticeship programme so that they could develop their own staff. Staff were encouraged to develop their skills and a practice educator had been employed to help support staff to do this.

Staff understood duty of candour and the need to be open and transparent and give patients and families a full explanation when things went wrong. We saw examples of duty of candour being mentioned in governance and team meeting minutes.

Good

Surgery

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.

BMI Circle Health Group had launched a new governance assurance framework in May 2021. The framework set out how the company governed transparently from ward to board and how this drove the continuous improvement of their clinical, corporate, staff and financial performance. The framework included terms of reference and the attendees required for each meeting that fed into the framework. Each meeting had a purpose and there were clear lines of accountability.

The hospital governance and clinical governance committee met monthly. We reviewed the last three sets of committee meeting minutes and all included evidence of audit feedback, incidents and complaints, information security, policies, the risk register and business continuity being regularly discussed.

With the exception of Critical Care, subcommittee reports, such as those from safeguarding, medicines management, and infection prevention and control (IPC) fed into the hospital governance meetings.

There were regular, monthly, staff meetings for theatre and ward staff. Staff meetings were recorded and regularly discussed key topics, such as safeguarding, staffing, quality and risk, IPC, and learning from incidents. Minutes we reviewed confirmed these discussions took place.

The medical advisory committee (MAC) oversaw clinical governance issues, the granting and renewing of consultants' practising privileges, and monitored patient outcomes. The MAC had good representation of different specialities and met regularly.

Arrangements were in place to manage and monitor contracts and service level agreements with partners and third-party providers. Contracts were reviewed on an annual basis, which included a review of quality indicators and feedback, where appropriate.

Management of risk, issues and performance

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

The service maintained a risk register, that documented the type of risk, location, risk rating, owner, review date, description and controls in place. The hospital governance and clinical governance committee met monthly to discuss the risk register and update the action plan.

We found risks listed on the hospitals risk register were realistic, relevant and understood by staff. In general, staff we spoke with were able to identify risks in their service and what actions were being taken to minimise the risk. The main risks identified related to staffing, primarily in conjunction with national shortages due to the COVID pandemic. Mitigation's in place included enhancing relationships with agencies to secure regular staff to fill shifts. Also, the hospital had successfully commenced an overseas recruitment campaign.

The provider had a system for managing critical safety alerts. They acted upon safety alerts and reviewed the practice in line with recommendations to ensure alerts' recommendations were complied with and risks were minimised.

Good

Surgery

There were effective systems to monitor quality and operational performance through internal and external audit programmes. Audit findings were discussed in the clinical governance committee meetings. Clinical auditing took place to an agreed schedule. Additionally, departmental health and safety checks were recorded so any non-clinical risks were controlled.

Arrangements were in place to manage and monitor contracts and service level agreements with partners and third-party providers. Contracts were reviewed on an annual basis, which included a review of quality indicators and feedback, where appropriate.

Information Management

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

The hospital had systems to capture and manage data to drive and improve quality performance. For example, the electronic reporting system meant the hospital could capture risks and monitor themes and trends. The system allowed the hospital to benchmark their outcomes against other comparable services both internally and externally.

Staff were able to access the relevant systems to gain access to the right information to perform their role. For example, they were able to get information on the latest policies and patient safety alerts. Noticeboards displayed up to date information regarding hand hygiene, waste segregation and clinical governance information relevant to department or ward.

Patient information and records were generally stored securely in all areas we visited, with one exception. Staff received information governance awareness training and followed a policy to keep patient information safe and secure.

The organisation had group policies and processes for governing information governance, security and personal data protection. All data controller registrations for the processing of personal data were maintained in accordance with the requirement of The UK Information Commissioners Office. The organisation held the formal certification in relation to the operation and management of its information.

There were effective arrangements to ensure data and statutory notifications were submitted to external bodies as required, such as local commissioners and the Care Quality Commission (CQC). There was transparency and openness with all stakeholders about performance.

Engagement

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

The service worked with local NHS trusts to meet the needs of the local population. The service asked all patients to complete a provider feedback questionnaire about their experience. They were also encouraged to complete reviews on search engine websites.

The results were collated on monthly basis and patient response, rates and rating within categories were ranked against all BMI hospitals. Results were reviewed at the clinical governance meetings and MAC meetings. Patient satisfaction was also discussed at the head of departmental meetings. Following review, the service and created an action plan to address trends from feedback.

Good

Surgery

Staff were able to give feedback through an annual staff survey. There was evidence of an action plan directly derived from the results of the staff survey, actions included expanding the benefits package, improving the offering of wellbeing services and introducing a recognition programme. Staff were aware of the actions taken in response to their feedback and were optimistic about improvements being made.

The Circle group had a weekly staff newsletter that was distributed across the whole group. This was used to recognise and celebrate staff achievements, such as long-service awards and qualifications staff had achieved. Various charitable events were promoted in the newsletters. The newsletter was also used as a vehicle to share updated procedural documents to the whole group.

The hospital provided ad hoc lunches for staff to celebrate different events. For example, during the inspection there was World Pharmacist Day, so staff from the pharmacy could request a free lunch from the staff restaurant on that day.

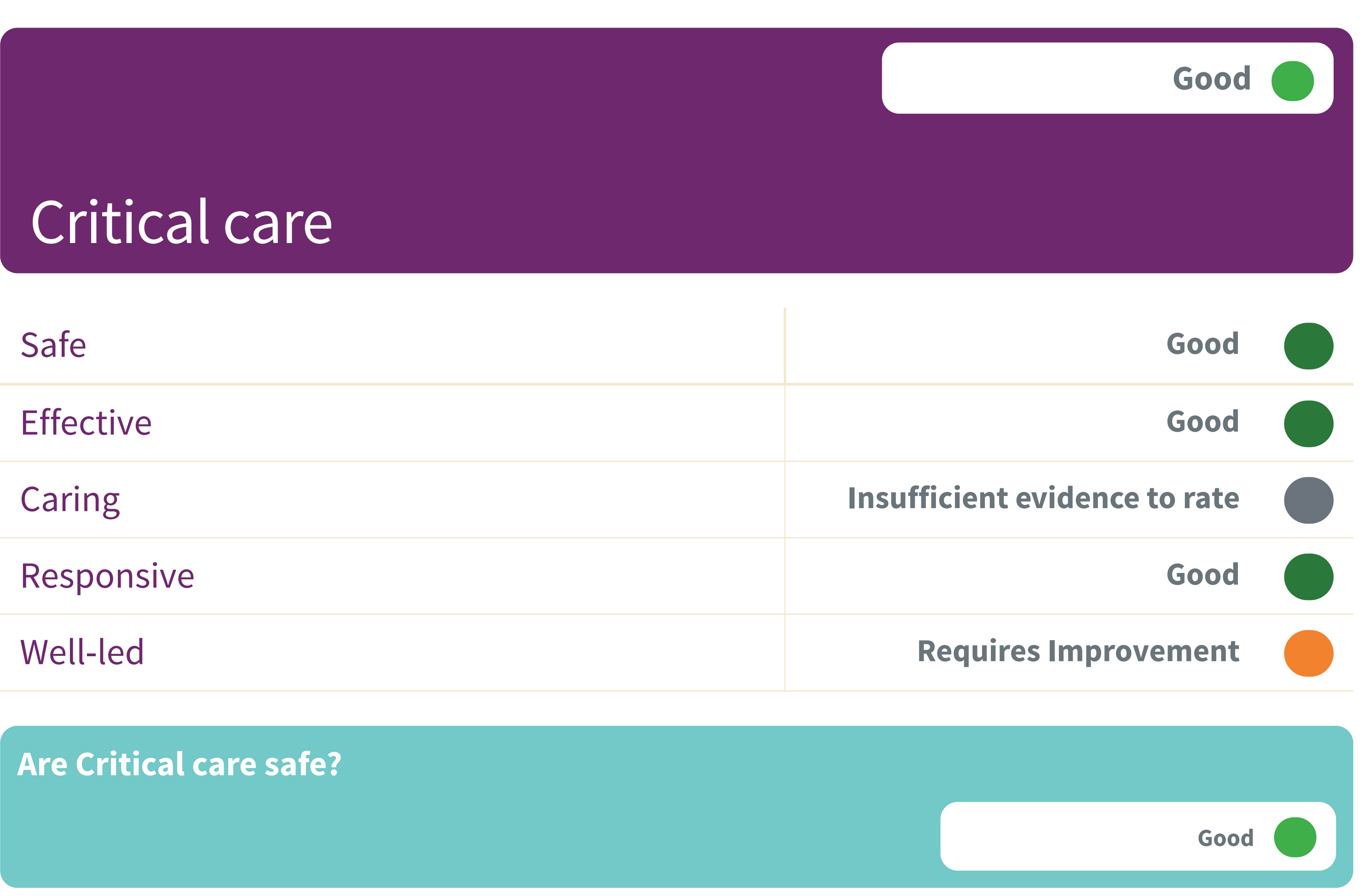
Learning, continuous improvement and innovation

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

Managers were responsive to feedback from patients and staff and worked to improve services. We saw noticeboards that displayed comments from patients and staff, and actions the service had taken to improve services.

In accordance with the hospital vision and values, the service aimed to recognise and resolve issues at the source, share and act upon areas for improvement, and continuously innovate and adapt. The service empowered staff to feel like they could make a difference and that their contributions were valued.

The theatre team offered apprenticeships and training opportunities which helped to develop the skills and offered career progression to individuals in the team. In addition, it meant the service could grow their own talent which helped with staff retention.



We rated it as good.

Mandatory training

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

Nursing staff received and kept up to date with their mandatory training. Records showed completion of mandatory training ranged from 81% to 100% across the hospital and all staff groups. Mandatory training was provided both electronically and by face-to-face training for practical skills.

Medical staff received and kept up to date with their mandatory training. Most medical staff completed mandatory training at their main place of employment. The service checked medical staff mandatory training, through the review of practising privileges process.

The mandatory training was comprehensive and met the needs of patients and staff. Records showed mandatory training covered essential subjects such as moving and handing, conflict resolution and equality and diversity.

Managers monitored mandatory training and alerted staff when they needed to update their training. Completion of mandatory training was monitored electronically. The hospital clinical educator accessed these records to monitor staff completion and alert staff when refresher training was due.

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.

Nursing staff received training specific for their role on how to recognise and report abuse. Records showed nursing staff completed training about safeguarding adults and children. The level of training staff completed met national guidance.

Good

Critical care

Medical staff received training specific for their role on how to recognise and report abuse. Most medical staff completed safeguarding training at their main place of employment. The service checked medical staff safeguarding training, through the review of practising privileges process.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The unit had adult referral packages and children and young people referral packages. These gave staff clear guidance and the relevant documents to use to complete adult or children and young people's referrals to the local safeguarding boards.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. The environment and equipment were visibly clean on the day of the inspection. Infection prevention and control environment audits showed the unit was cleaned to the set standards most of the time. The audits demonstrated that where shortfalls were identified, action was taken promptly to remedy the shortfall.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff followed a schedule for cleaning bed spaces, equipment and the general environment. Audits demonstrated staff adhered to the schedule.

Staff followed infection control principles including the use of personal protective equipment (PPE). There was guidance and training for staff about the use of appropriate personal protective equipment. Hand gel was available throughout the unit. This included at all bed spaces, administration areas, equipment storage areas and at the entrance to the unit.

National guidance was followed, including routine testing of patients prior to admission, routine testing of staff and provision of PPE to reduce the risk of transmission of COVID-19. One of the three bed areas was an isolation pod that could be used to protect patients who were at increased risks if acquiring an infection or to reduce risk of transmission of infection from an infectious patient to other patients.

Staff cleaned equipment after patient contact. Cleaning schedules and records of cleaning carried out showed all equipment was cleaned after use.

Environment and equipment

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

Patients could reach call bells. As the unit was closed at the time of the inspection, we were not able to observe if staff responded promptly to call bells. However, planned staffing levels meant staff would continually observe patients and respond promptly to verbal and non-verbal requests for assistance.

The design of the environment did not follow the current national guidance and the age of the unit meant there was no requirement for the service to meet the current national guidance. Managers and staff were aware of environmental shortfalls and acted to reduce risks this might pose to patients. This included only having chairs for patients on the unit when they were well enough to sit out of bed to avoid unnecessary cluttering of the environment.

Good

Critical care

Staff carried out daily safety checks of specialist equipment. Records showed staff consistently carried out daily safety checks of emergency equipment and bedside equipment. Staff also checked bedside equipment before the admission of a patient.

The service had facilities to meet the needs of patients' families. Families and relatives could use a relative's room situated on the adjoining general ward. Patients being treated and cared for in the critical care unit, retained their side room on the general ward, which relatives could make use of.

The service had enough suitable equipment to help them to safely care for patients. Equipment, including emergency equipment was available. Processes were in place and followed by staff to ensure equipment was safe to use. Staff disposed of clinical waste safely, in line with guidance.

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.

On the critical care unit, staff identified deteriorating patients and escalated them appropriately. Patient records showed staff continuously observed patients and identified changes in their conditions. Staff escalated deteriorating patients to the medical staff for critical care. Staff had immediate access to specialist equipment, such as resuscitation equipment, to respond to patient deterioration promptly. A service level agreement supported prompt transfer of patients to the acute NHS critical care services if needed.

The critical care unit did not have a formal critical care outreach service that staff on the general wards escalated deteriorating patients to. However, the critical care medical and nursing staff provided support and guidance to staff on the general wards. At the time of the inspection, due the unit being closed, the critical care lead intensivist had advised the hospital to only admit low risk patients. This was to reduce the possibility of patients requiring critical care whilst the unit was temporarily closed.

Staff completed risk assessments for each patient on admission and reviewed these regularly. Patient records included assessments of patient risks, which included risk of pressure ulcers malnutrition, venous thromboembolism, and infections. Patient records prompted staff to complete risk assessments and to review them at least three times in a 24-hour period.

Staff knew about and dealt with any specific risk issues. For example, staff followed a sepsis care pathway based on the national sepsis six care bundle for patients assessed at risk of potentially having sepsis.

The service did not have formal 24-hour access to mental health liaison and specialist mental health support. However, all patients admitted for abdominal surgery had received psychological support prior to their admission and had access to psychological support following their surgery. If staff were concerned about patients' mental health, a private referral was made to mental health practitioners.

Staff shared key information to keep patients safe when handing over their care to others. Staff followed a structured process to hand over care to the general wards when a patient was discharged from the critical care unit. This ensured the receiving staff had all relevant information such as patients' medical history, current physical conditions and any anxieties the patient was experiencing.

Good

Critical care

Nurse staffing

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

The service had enough nursing to keep patients safe. Staffing levels and skill mix met national guidance. All nursing staff, including bank and agency nurses, had a post registration qualification in critical care nursing. Patients were looked after by nurses who had the appropriate skills and experience.

Managers accurately calculated and reviewed the number and grade of nurses needed for each shift in accordance with national guidance. Staffing rotas were organised against planned admissions to the unit and were adjusted according to any change to the planned admission list. Staffing numbers met the national guidance, with level 3 patients having one to one nursing care. Although the unit only had three beds, rotas were arranged so there was a supernumerary member of the nursing staff to coordinate the shift and provide support to the other nursing staff.

The ward manager could adjust staffing levels daily according to the needs of patients. The nurse staff rota showed that staffing numbers were altered to meet the bed occupancy and critical care level of patients in the unit. Nursing staff (both permanent and bank) were rostered as being on call to come in and support the unit if the dependency of patients changed.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Only bank and agency nurses who had a post registration qualification in critical care nursing were used. Bank nurses followed the same induction programme as permanent nursing staff. Agency nurses had an induction to the hospital and the critical care unit.

Medical staffing

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

The service had enough medical staff to keep patients safe. There was a critical care doctor with critical care and airway management skills and experience on duty 24 hours, seven days a week. Patients were reviewed by consultants twice a day. There was always one face to face review, with the second review being, dependant on the patient’s condition and recovery, either a face to face or a telephone review with the staff looking after the patient. The critical care doctor recorded the detail and outcome of the consultant’s telephone review in patients’ records.

The service always had a consultant on call during evenings and weekends. A consultant intensivist provided 24 hour seven days a week on call service for patients. They attended the hospital within 30 minutes if the patient required their attention. Staff said they could always access medical support when they needed it.

Records

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

Good

Critical care

Patient notes were comprehensive, and all staff could access them easily. Staff completed patient records, including risks, records of care and treatment provided and communication with patients and their relatives. Records were legible, signed and dated.

When patients transferred to a new team, there were no delays in staff accessing their records. Patients records were paper based and travelled with the patient during their treatment journey, including discharge from the critical care unit to the general wards. Staff completed transfer notes and accompanied the patient to the place of discharge to ensure accurate handover of records and patient care and treatment information.

Records were stored securely. Patient records were stored at the bed space of each patient, so staff had immediate access to them. The service assessed this as secure: records were always in sight of staff and access to the unit was restricted by a swipe access door.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines records were complete and contained details on patient allergies, medicine dose, when patients received them, and controlled drugs were double checked.

Staff reviewed patients' medicines regularly and provided specific advice to patients about their medicines. A pharmacist who had a specialist interest in critical care checked patient's medicines and prescriptions daily.

Staff stored and managed medicines in line with the provider's policy. Staff followed a process that ensured enough stock of medicines. All medicines were stored safely in locked cupboards.

Incidents

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

The service had a process to report incidents. Staff reported incidents electronically, this included serious incidents, concerns and near misses. The hospital incident reporting policy gave staff guidance about reporting incidents.

For detailed findings about incidents, please see the surgery section of this report.

Are Critical care effective?

Good

We rated it as good.

Good

Critical care

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies and procedures reflected national guidance, including the guidelines for the provision of intensive care services, and staff had easy access to them electronically. Staff delivered care and treatment in line with national standards.

Managers checked to make sure staff followed guidance. Audits, for example records audits and hand hygiene audits, were used to monitor that staff followed guidance and where needed managers acted to ensure staff followed guidance.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff made sure patients had support with nutrition and hydration to meet their needs. Most patients admitted to the unit needed specialist nutritional support following their surgery. Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Staff had the skills to support patients who required specialist feeding and hydration techniques.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Patient records showed staff completed fluid intake and output and nutrition records.

Staff used a nationally recognised screening tool to monitor patients for risk of malnutrition. Staff completed nutritional assessments for all patients on the unit.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patient records included pain assessments. Staff used a variety of tools to assess whether patients had pain, which included verbal and non-verbal assessments of pain.

Patients received pain relief soon after it was identified they needed it, or they requested it. Feedback from patients collected by the unit indicated patients received pain relief medicines to minimise pain after surgery.

Patient outcomes

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

Good

Critical care

The service participated in relevant national clinical audits. The service reported outcomes to the Intensive Care National Audit and Research Centre (ICNARC).

Outcomes for patients were positive, consistent and met expectations, such as national standards. Results from the ICNARC data showed good outcomes for patients that met national recommendations. Staff told us data was collected for the outcomes of patients undergoing extensive abdominal surgery for. This included outcome data for Peritoneal Malignancy Institute in Basingstoke which included patients treated at BMI Hampshire Clinic and the nearby acute NHS trust. Staff told us this showed good outcomes for patients.

The service had an expected risk of readmission for elective care that was like the England average for a similar critical care service. Between April and July 2021, out of 31 patients there had been three unplanned readmissions to the critical care unit within 48 hours.

Managers and staff carried out a programme of audits to check improvement over time. Managers used information from the audits to improve care and treatment. Staff completed a variety of clinical and environmental audits to provide assurance about local practice in their areas.

Managers shared and made sure staff understood information from the audits. We were told information was shared through virtual team meetings and the unit's closed social media group.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All permanent nurses had a post registration qualification in critical care nursing. All bank nurses and agency nurses who worked on the unit were required to have a post registration qualification in critical care nursing. This met national guidance. All permanent nursing staff completed national critical care competencies. This training ensured patients were always cared for by a team of nurses who had the appropriate skills and experience.

The practising privileges process ensured that all medical staff working in the critical care service had completed relevant training and they had the relevant skills and experience. For detailed findings about practising privileges process, please see the surgery section of this inspection report.

Managers gave all new staff a full induction tailored before they started work. All new staff (permanent and bank staff) completed an induction programme tailored to their role. This included a supernumerary period to learn the role and training sessions. All agency staff completed an induction to the critical care environment.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff were supported to develop their skills. Nursing staff received appraisal of their work annually. Appraisal rate for nurses across the hospital was 92%. Medical staff had their work appraised in their main place of employment and there was a process to share appraisal information between the service and the acute NHS trust.

The clinical educator supported the learning and development needs of staff. Although there was not a dedicated critical care clinical educator, there was a clinical educator for the hospital who oversaw the education of all staff at the hospital, including the critical care staff.

Managers did not hold formalised team or departmental meetings. Staff told us information was shared through virtual informal meetings or private social media groups.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The service ensured necessary staff were involved in assessing, planning and delivering care. Specialist nurses, psychologists and nutritionists supported patients having extensive abdominal surgery. All patients had routine access to physiotherapists and pharmacists. Access to other health professionals, such as mental health specialists and speech and language therapists were arranged as required.

Staff worked across health care disciplines and with other agencies when required to care for patients. The service worked collaboratively with the local NHS acute trust to share care and treatment of patients. During the COVID-19 pandemic BMI The Hampshire Clinic had initially loaned their critical care equipment to the local acute NHS trust. During the second phase of the pandemic they supported the local NHS acute trust with additional abdominal surgery to release NHS critical care beds for the treatment of patients with COVID-19. This had meant the acute NHS teams had worked alongside the staff from BMI The Hampshire Clinic, including staff working in the critical care service. Staff reported they had worked as a single team to provide safe and effective care and treatment to patients.

Seven-day services

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

Consultants reviewed patients twice a day. There was always one face to face review, with the second review being, dependant on the patient's condition and recovery, either a face to face or a telephone review with the staff looking after the patient. The critical care doctor recorded the detail and outcome of the consultant's telephone review in patients' records. There was a critical care doctor on site 24 hours seven days a week. A consultant intensivist provided 24 hour seven days a week on call service for patients. They attended the hospital within 30 minutes if the patient required their attention.

Patients had access to physiotherapy seven days a week and access to pharmacy services and other allied health professionals, such as psychotherapy seven days a week if needed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Records showed all staff had completed training about consent, which included the Mental Capacity Act. It was the responsibility of the consulting surgeon to, where required, asses the patient's capacity to consent. Staff demonstrated they had a good understanding about their responsibility towards the Mental Capacity Act.

Staff made sure patients consented to treatment based on all the information available. The consent process ensured patients fully understood the surgical procedure, risks associated with it and the reason for admission to critical care. Consent to procedures was recorded in patients' records.

Are Critical care caring?

Insufficient evidence to rate

Insufficient evidence to rate

We were not able to make a judgement about this domain. The critical care unit was closed at the time of our inspection, so we could not observe any interactions between staff and patients or speak to patients and their relatives.

The staff we did speak with demonstrated in conversations they considered patients at the centre of the service and were committed to treating them with kindness and dignity. They understood how patients' illnesses and being treated in critical care had an impact on their emotional wellbeing. Staff explained that one of their essential roles was to support both the patient and their families emotionally through their critical care admission.

The unit received thank you cards from patients. A common theme in all the thank you cards was the kindness, compassion and professionalism of staff that made a difficult time more bearable for patients.

Are Critical care responsive?

Good

We rated it as good.

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the community served. The service provided care and treatment for patients undergoing elective surgery who required critical care postoperatively for a short period of time. The service did not provide an emergency service, other than accommodation and treatment for patients whose conditions deteriorated on the general wards of the hospital.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. There had been no mixed sex breaches in the unit in the past 12 months.

Facilities and premises were appropriate for the services being delivered. Due to the age of the critical care unit, it was not required to meet all the current national guidance for the environment of a critical care unit. The unit was small and did not have all the facilities a modern critical care unit would have. However, staff worked hard to make the best of the environment and were able to provide safe and responsive care to patients admitted to the unit.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems and learning disabilities. Although there was no mental health support provided by the hospital, staff accessed mental health and learning disability support through private referrals.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff gave examples where they had made reasonable adjustments to meet the specific needs of people. Preadmission assessment processes identified if patients needed additional resource or reasonable adjustments to meet all their needs.

The unit was not designed to meet the needs of patients with dementia. The unit rarely provided care and treatment to patients with dementia and currently was not designed to meet the needs of patients with dementia. However, resources such as twiddle muffs for distraction and occupation, were available to support the care and treatment of a patient with dementia if they were admitted to the unit. Staff carrying out preadmission assessments completed 'This is me documents' for patients with dementia and learning disabilities.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to translation services for patients where English was not their first language, and this included access to British Sign Language interpreters.

Access and flow

People could access the service when they needed it and received the right care promptly. The service admitted, treated and discharged patients in line with national standards.

Managers made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The service provided critical care for planned elective surgery, with surgery planned to make sure there was bed availability for the patient.

Managers and staff worked to make sure patients did not stay longer than they needed to. Most patients were discharged from the unit within four hours of the decision to discharge. Between 1 April 2021 and 31 July 2021, 24 of 31 patients were discharged within four hours of the decision to discharge and seven patients were discharged within 24 hours of the decision to discharge.

The service moved patients only when there was a clear medical reason or in their best interest. All transfers made to NHS acute services were for clinical reasons. There were no non-medical transfers between April and July 2021. This met national standards.

Staff did not move patients between wards at night. There had been no patients discharged from the unit between the hours of 10pm and 7am between April and July 2021. This met national standards.

Learning from complaints and concerns

Good

Critical care

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. Information about how to make a complaint was available on the provider's website.

Managers investigated complaints and identified themes. Investigation of complaints was managed by the hospital leadership team.

For detailed findings about management of complaints, please see the surgery section of this report.

Are Critical care well-led?

Requires Improvement

We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service.

There was a clear leadership structure for the critical care service. The unit was led by a lead critical care nurse, who was accountable to the quality and risk manager. Clinical leadership for the unit was led by a consultant intensivist. The two members of staff we spoke with spoke positively about the leadership of the critical care service, describing the leadership as being supportive and working well with everyone.

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.

Staff on the unit expressed a vision to expand the critical care service, however this had not been developed into a formal strategy or plan.

However, the critical care service supported the hospital wide vision and strategy. For detailed findings about the hospital wide vision and strategy, please see the surgery section of this report.

Culture

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

Staff we spoke with were positive, enthusiastic and were proud to work for the service. They felt supported, respected and valued.

Staff we spoke with described they focused on the needs of patients receiving care and gave examples of how they showed kindness and compassion towards patients.

Leaders supported the well-being of staff. Staff could access support resources through an employee assist programme and virtual meetings were held to support staff through the current COVID-19 pandemic.

The service promoted equality and diversity in daily work. The critical care work force was a supportive and diverse team with no instances of inappropriate behaviours relating to equality and diversity.

Governance

Leaders did not operate a critical care governance process. There was lack of opportunities to meet, discuss and learn from the performance of the service.

Leaders did not operate a critical care governance process. Governance processes for the service were managed as part of the general ward governance processes. The critical care team reported to the ward manager who collectively represented both services at clinical governance meetings and daily communication cells. There was no structured approach about what information was reported to the ward manager.

There was no evidence in the last three hospital wide clinical governance meeting records that there had been any review of the critical care service.

There were no standalone departmental meetings for the critical care service to review the performance of the service or to formally share information. There was no formal process to identify actions required and monitor that actions were completed. There was no individual responsible for escalating risks. However, information was shared through informal methods, such as by a private social media platform.

The lack of a formalised governance process for the critical care service indicated the service had not fully considered the clinical governance standards of the Guidelines for the Provision of Intensive Care Services version 2 2019.

Management of risk, issues and performance

Leaders and teams did not proactively identify, monitor and review risks. There was limited use of systems to manage performance. Staff did not have formal opportunities to contribute to decision-making to help avoid financial pressures compromising the quality of care. They had plans to cope with unexpected events.

The service had some arrangements for identifying and recording risks. However, there was no clear process to proactively identify, monitor and review risks. Management of risk was reactionary. Staff identified risks through incidents and recorded these on an electronic recording system. However, there was no evidence of a process to proactively review the service to identify any risk or potential risks. There was no evidence of a process to identify actions required to lessen risk and to keep risks under review.

The hospital wide risk register included one risk that related to the critical care service, this was about risk of contamination of water supply.

Lack of formalised departmental meetings meant staff were not given the opportunity to contribute to decision making about the management of risks, issues and performance of the service.

Good

Critical care

There was limited use of systems to manage performance. The service carried out some audits, such as environmental audits, to monitor quality and acted when results identified improvement was needed.

The hospital had a business continuity plan. This detailed the actions staff needed to take in the event of unexpected events to ensure patient safety was not affected.

Information Management

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

The service collected some data and analysed it. For example, they used the data from the ICNARC submission and from infection prevention and control audits to provide a picture about how the service was performing. However, there was no process to interrogate other data, such as patient feedback, to provide a picture about the patient experience.

Staff could find information they needed. Policies and procedures were stored electronically which staff could easily access.

The service had arrangements to ensure data or notifications was sent to external bodies as required. For detailed findings about notifications to external bodies, please see the surgery section of this report.

Engagement

Leaders engaged with staff to plan and manage services, and there were some mechanisms to engage with patients and the public. They collaborated with partner organisations to help improve services for patients.

The critical care service did not have a formal process to gather patient's views and experiences of the service to shape and improve the service. They did collect all the thank you cards and letters from patients and their families and shared that information with staff. However, there was no analysis of any patient feedback.

The hospital said patient feedback about their experience of the critical care service was gathered by staff on the wards and fed back to the critical care service. However, there was no evidence about how this information was used by the critical care service or that the information was fed back to the critical care service.

Leaders engaged with staff through annual staff surveys, electronic communication, and in informal discussions. Staff we spoke with felt their view and opinions were listened to.

Leaders collaborated with partner organisations to help improve services for patients. They had a good working relationship with the local acute NHS trust to deliver the abdominal surgery for the Peritoneal Malignancy Institute.

Medical care (Including older people's care)

Good

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

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

Good

Our rating of safe improved We rated it as good.

Mandatory training

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

The mandatory training was comprehensive and met the needs of patients and staff. We did not see compliance rates for endoscopy and oncology, but their overall rate for nursing staff was 94%.

Mandatory training was a mixture of face to face and online. It included but was not limited to fire safety, consent, basic life support and equality and diversity. Specialist staff received additional training that was role specific. For example, clinical staff in the endoscopy unit completed cannulation training. The oncology nurses received specialist training in systemic anti-cancer therapy.

Managers monitored mandatory training and alerted staff when they needed to update their training. There was a specific notice board for training and education which displayed course availability and compliance rates. Drop-in sessions were provided across weekdays. Staff were supported to access learning and support with information technology.

Safeguarding

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

Most staff could explain how they would respond if they witnessed or suspected abuse. They would report it to the director of clinical services, who was the safeguarding lead. We spoke with a member of staff who was unsure who the safeguarding lead was and how to make a referral. However, they described a safeguarding concern that had not been identified during the pre -assessment process. They identified concerns related to the patient’s understanding. They described how they escalated their concern and followed hospital policy to keep the patient safe.

Good

Medical care (Including older people's care)

Nursing staff received training specific for their role on how to recognise and report abuse. Ninety nine percent of staff had completed safeguarding adults' level 1 training, 93.2% had completed safeguarding level 2 training, and 100% of staff had completed safeguarding level 3 training. Managers made sure staff completed safeguarding training. This was monitored at local and corporate level.

There was a dedicated safeguarding lead at the hospital and for the company. They were trained to safeguarding level 4. Staff had access to support with safeguarding matters, this included out of hours support.

Cleanliness, infection control and hygiene

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

Staff followed infection control principles including the use of personal protective equipment (PPE). PPE was stored on wall mounted dispensers. Hand gel and PPE was readily available. Staff used them in line with guidance. They were bare below the elbows, wore face masks and cleaned their hands between patient contacts.

Staff cleaned equipment after patient contact. There was a clear clean to dirty pathway for the management of endoscopes. The bedside clean took place immediately after the completion of the endoscopic procedure. This was followed by a manual clean of the endoscope. The scopes were sent to an off-site hub for decontamination in appropriate trays and packaging. Following this pathway ensured there was no contamination between clean and dirty endoscopes. Cleaning records were up-to-date and demonstrated all areas were cleaned regularly.

The clean and dirty flow for the scopes followed the process outlined in the national guidance. Scopes were tracked using a barcode system. The hospital complied with the regulatory requirements outlined in the English Health Technical Memorandum (HTM) 01-06: Decontamination of flexible endoscopes and, for sites in Scotland and Wales.

Enbourne ward included four specific rooms to provide systemic anti-cancer therapy to patients with cancer. Patients received treatment as a day case and did not stay overnight. Each room was ensuite and well ventilated. All soft furnishings were smooth and seamless and easy to clean. There was enough storage space for patients' possessions to discourage clutter. This included bedside waste disposal receptacles. Floors were covered with vinyl up to the walls to make cleaning easier. However, we saw the skirting board was loose from the side of the wall in a vacant room on Enbourne ward. This meant it would be difficult to keep this area clean as dust could collect in the gap.

Environment and equipment

The maintenance and use of facilities generally kept people safe.

The endoscopy unit was built in 2018 and looked well maintained. There were six bays separated by disposable curtains which were all in date. The unit included other rooms such as a specific room for patients in distress. Patients could reach call bells and staff responded quickly when called. The endoscopy unit was patient centred.

The unit had enough suitable equipment to help them provide safe care and treatment. Each bay had oxygen and suction. The hospital had an appropriate process in place to acquire, validate, periodically test, maintain and annually re-validate all flexible endoscope reprocessing equipment. We saw evidence of up-to-date safety checks.

They used an electronic track and trace application. It tracked flexible endoscopes and recorded each stage of the reprocessing cycle.

The hospital had a policy to guide staff and raise awareness about what to do in the event of a cytotoxic spillage. They also stocked spillage kits for patients receiving systemic anti-cancer therapy (SACT).

Specimens for histology and cytology were transported to the histology department at a local NHS trust. They were transported in appropriate containers and packaging and labelled as diagnostic specimens- UN3373. This ensured they were complying with the requirements of the Department for Transport guidance for packaging and transport requirements for patient samples- UN3373.

Staff carried out daily safety checks of specialist equipment. Equipment on the endoscopy unit and Enbourne ward had an annual electrical check known as portable appliance testing. New equipment was asset tagged, sent to the facility department, and added to a specific register. This flagged when their annual reviews were due.

There was fully stocked resuscitation equipment available in the endoscopy suite and the ward area. They were tamper-proof and included a list detailing the individual items that needed to be held. Staff replaced any used items immediately or when they had past their expiry date. There was evidence of daily checks of equipment and consumables which were all in date. Resuscitation guidelines were attached to the resuscitation equipment to help support staff in an emergency.

Sharps such as needles were disposed of in line with national guidance. Sharps bins were stored safely in designated secure areas until collected.

There was a water cooler in the endoscopy unit for patients to use. We highlighted this immediately due to concerns that bacteria such as pseudomonas and legionella could grow in the water bottle and dispensing nozzle. Management advised they had risk assessed this and documented their risk assessments.

Patients received systemic anti-cancer therapy (SACT), on Enbourne ward. They used drinking water from the kitchen. There was a 30-day filter on the tap. This was to mitigate any potential waterborne pathogens. There was no expiry date on the filter tap. However, managers advised they were changed monthly, and they maintained a record. They reminded staff to use indelible stickers to record the expiry dates following the inspection.

There was clear signage reflecting fire exits on the endoscopy unit and Enbourne ward. Fire extinguishers were in date. However, we saw furniture placed in the corridor leading to the fire exit on Enbourne ward.

Staff disposed of clinical waste safely. They used a colour coding guide to separate waste for disposal. There was a poster displaying their guide in the sluice. Clean linen was prepacked in brown plastic bags. However, used linen was also disposed of in the same colour bags. This could be confusing for staff.

The arrangement for the control of substances hazardous to health (COSHH), were not always adhered to in the endoscopy unit. We saw a container of cleaning tablets that was a COSHH product that was not stored securely. We highlighted this to staff, and they locked it away in a designated cupboard immediately.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

Good

Medical care (Including older people's care)

Consultants assessed patients medically in the outpatient clinic for endoscopy procedures. Nursing staff also completed a pre-treatment assessment on a specifically designed pathway with patients prior to an endoscopy. This was to check their fitness for the procedure. The pathway provided prompts of the observations that should be undertaken within specific time intervals. We checked one set of notes for a patient who had an endoscopy procedure. Staff had recorded observations of the patients' pulse rate, oxygen saturations, respiratory rate, temperature and blood pressure. The observations were completed to reflect the prompt times. Staff would be able to identify early signs of patients' deterioration.

Endoscopy staff used the World Health Organisation (WHO) guidelines 5 steps to safer surgery to ensure compliance. Their audit results for compliance with the WHO checklist were 99% in August 2021 and 98% for venous thromboembolism risk assessments. The hospital complied with the WHO checklist.

Oncology nurses completed an assessment in advance of commencing systemic anti-cancer therapy (SACT). This included investigations such as blood tests, height and weight in advance of being reviewed by a consultant and considered suitable for treatment. This was part of a specifically designed care pathway, for oncology patients on admission. The patient's assessment included information about the risks of SACT, and how these risks could be managed as well as additional tests and follow up appointments and support.

Staff completed risk assessments for each patient on admission/arrival. They used a recognised tool, and reviewed this regularly, including after any incident.

Oncology nursing staff were trained to use the United Kingdom Oncology Nursing Society (UKONS), triage tool. They provided on call cover and could use the triage tool with patients who had received SACT. They could offer a telephone assessment and triage of patients who may be suffering from side effects of SACT. They contacted the patient's consultant if the triage indicated that they needed to be admitted. This was to determine the most appropriate setting to admit the patient to. Successful triage supported oncology staff to recognise emergencies and potential emergencies to ensure that immediate assessment and required interventions were arranged.

If a patient needed immediate help during SACT treatment, staff would telephone the consultant. If the oncology consultant was not present staff would contact the resident medical officer who was on site 24 hours a day. The hospital had a transfer agreement with a nearby NHS trust and a policy for a patient who became unwell.

The hospital used the National Early Warning Score (NEWS)2 as their early warning system for identifying acutely ill patients. Their audit result for compliance with the tool was 95% in July 2021. They used tools endorsed from NHS England/Improvement to identify acutely ill patients.

We did not observe any staff handovers or safety huddles. However, staff told us huddles were used to identify concerns or potential issues for the day. The huddle highlighted information from the corporate senior team such as any patient safety alerts that may affect the service. Staff shared key information to keep patients safe when handing over their care to other

Nurse staffing

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

Good

Medical care (Including older people's care)

The service had enough nursing and support staff to keep patients safe. Managers limited their use of bank and agency staff and requested staff familiar with the service and experienced in endoscopy. Bank and agency staff received the same training as substantive staff and were familiar with their policies and procedures.

Two oncology nurses had to be available for systemic anti-cancer therapy to proceed. We looked at some recent staff rotas and saw there were always two on duty. An oncology nurse was transferred from another location within the company if there was only one available at this location.

The ward manager could adjust daily staffing levels, according to the needs of patients. They used an internal acuity tool to plan. Staff hours could be increased or decreased depending on the acuity of the unit. For example, if a member of nursing staff was not required to work their full shift, they could take some time owing or complete some non-patient facing duties, such as audit or policy review.

Medical staffing

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

Endoscopic procedures were completed by specialist consultants. They had consultant posts in NHS trusts and worked on an ad hoc basis. Medical staff worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital.

A resident medical officer (RMO), provided 24-hour, seven day a week cover at the hospital. They did not cover the intensive care unit. This was covered by separate staff. The RMO cover was supplied through an agency who also checked their competency. This included ensuring they had completed all the required training which included advanced life support.

Staff escalated immediate concerns to the RMO. They reported timely access to consultants who they also escalated concerns to.

Records

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

Patient notes were comprehensive, and all staff could access them easily. We reviewed five sets of notes for patients who had an endoscopic procedure. Their consent forms, pre-assessments, COVID-19 risk assessments, observation charts, medicine charts and discharge documentation were fully completed. Scope tracing stickers were included in every set of notes and entries included times, dates, and signatures.

We reviewed four sets of records for patients who had received systemin anti-cancer therapy. All consent forms, COVID-19 risk assessments, observation charts, medicine charts, health questionnaires, risk assessments, treatment plans, and specific pathways were completed in full. Two of the patients had also called the out of hours oncology helpline. The United Kingdom oncology nursing society triage forms were fully completed. Entries included times, dates and signatures. Staff maintained clear contemporaneous records, which they completed in full. They had access to up-to-date, accurate and comprehensive information on patients' care and treatment.

Records were not stored securely on Enbourne ward where oncology patients were treated. They were stored on filing shelves in the staff room where handovers took place. The shelving had a pull-down door which could be locked to maintain confidentiality. However, the notes were stored on the filing shelves, and the cabinet was not closed or locked. The room was open, with notes clearly visible. We highlighted this to staff. They did not attend to our concerns immediately. However, they were locked and stored securely the following day.

Medicines

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

Piped oxygen was available in the endoscopy procedure room and recovery bays.

Medicines were stored securely in locked cupboards. All treatments had storage instructions on the medication label. Medicines that required storage below a certain temperature were stored in a locked fridge specifically for that purpose. The room temperature where medicines were stored was monitored and maintained to ensure they were stored at the correct temperature. Staff were aware of actions to take if temperatures were not within the minimum and maximum range, and there was guidance on the recording sheets.

All treatments relating to a single patient were kept together in zip lock bags in the relevant storing location. Intravenous fluids for oncology patients on Enbourne ward were stored in a room that could only be accessed by keypad entry.

Medicines were available in endoscopy and Enbourne ward to provide immediate treatment for any adverse reactions to sedation or pain medicines.

Chemotherapy transfusions were prepared in pharmacy in sealed bags labelled with patient’s names. Chemotherapy spillage kits were available and given to patients for use at home, in case of a medicine spillage.

Controlled drugs were checked daily by trained staff and recorded in the relevant controlled drug registers. Their pharmacist completed spot checks to ensure drugs were prescribed, stored and managed in line with their medicines policy.

Records for checking controlled drugs demonstrated that the Medicines Policy was followed. The process for maintaining safe checks was effective in the endoscopy unit and the ward were patients received systemic anti-cancer therapy.

Incidents

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

Staff knew what incidents to report and how to report them. All incidents were reported on the hospital incident reporting system. The level of harm was assessed as moderate, severe or death.

Staff understood the duty of candour. They were open and transparent. They gave patients and families a full explanation when things went wrong. They were familiar with their process outlined in the company's Being Open and Duty of Candour policy. The policy was approved in March 2021.

Staff received feedback from investigation of incidents, both internal and external to the service. We were given examples of learning from incidents. For example, a patient had been unnecessarily delayed for surgery which meant they had

Good

Medical care (Including older people's care)

fasted for an extended length of time. The incident was investigated, and staff received clear feedback on what should have happened. Learning was shared across all teams with clear guidance that patients could be offered fluids up to two hours prior to planned surgery. There was guidance for how to complete a safety brief and debrief on the staff education notice board. This helped to ensure consistent practice and support.

There was evidence that changes had been made as a result of feedback. The hospital collated incidents onto a dashboard and tracked themes for all departments. There were no never events, serious incidents, or unexpected deaths from March – August 2021. We saw notice boards in staff areas with details of incidents. These included numbers, themes, and learning that had been identified to prevent something similar. Lessons were shared and there was an emphasis on learning, not blame.

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

Good

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care, according to best practice and national guidance. All committee members were responsible for ensuring new policies were disseminated to all staff. Staff were obligated to check policy updates and ensure they had access to the intranet for the most up- to- date policy.

The endoscopy and oncology team belonged to specialised cluster groups, along with a corporate steering group. The steering group and cluster groups worked together to ensure policies were maintained in line with national standards. Best practice was shared throughout the group.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We saw specific instructions in endoscopy notes and care plans about food and hydration requirements. Patients who were due to attend for a colonoscopy were given detailed advice on how to prepare for the procedure. This included advice regarding dietary and fluid intake. Nursing staff offered patients a drink and light snack prior to discharge after endoscopy procedures.

Oncology staff completed a dietary requirement form if a patient had any food or beverage allergies/intolerance's. This was following their consultant’s request to commence systemic anti-cancer therapy. The catering team were notified of any specific dietary requirements prior to the patients’ attendance. Staff were able to refer patients to a dietitian if required.

Pain relief

Patients undergoing a gastrointestinal endoscopy were offered a throat spray to reduce discomfort. They could also be offered intravenous sedation, to minimise any discomfort or pain.

Good

Medical care (Including older people's care)

Medical staff performed colonoscopies under intravenous sedation, to ensure a person was relaxed and comfortable during the procedure.

Staff in oncology monitored patients' pain when they received systemic anti-cancer therapy.

Patient outcomes

Staff the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under a relevant clinical accreditation scheme.

The endoscopy unit achieved accreditation with the Joint Advisory Group (JAG), in December 2020. Endoscopy units in the UK are regularly assessed by the JAG on Gastrointestinal Endoscopy. This is the body responsible for upholding the quality of endoscopy at a national level. The JAG provides clear and detailed standards, and frameworks within which to reach the acceptable standards for competence in endoscopic procedures and for certification, accreditation and re-accreditation.

They had been independently assessed to ensure the service provided a safe, effective accurate diagnosis and treatment. They were assessed to ensure the service was efficient and dignified, with safe, effective training and support for staff.

The endoscopy unit had a system for the monitoring of their clinical performance data for endoscopy procedures performed at the hospital. They also used an electronic system to record and monitor patients who required follow up. For example, they recorded the reason for the patient's referral, the procedure, and diagnosis. They recorded if any follow up was required, and if so, by what date. The hospital had a process to compare their performance against other providers, and ensure patients received any recommended follow up and treatment.

Oncology patients were discussed in a multidisciplinary team meeting. This provided opportunity for peer review and benchmarking. Oncology staff monitored patient's outcomes when they returned for review, and further systemic anti-cancer therapies. This was recorded in patients' medical notes. The service contributed to the Private Healthcare Information Network (PHIN).

The service participated in relevant national clinical audits. For example, the oncology department participated in a twice-yearly audit of the United Kingdom Oncology Nursing Society (UKONS), triage tool forms used. We reviewed the audit undertaken of the UKONS management guidelines completed in 2021. The data submitted by the hospital stated that the hospital was 94% compliant.

Competent staff

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

Managers gave all new staff a full induction tailored to their role before they started work. Nursing staff completed a four-week induction programme. This included a mix of training, protected time for review of policies and procedures, and clinical work under supervision. They were supernumerary during this period.

Managers supported staff to develop through yearly, constructive appraisals of their work. Most nursing staff had received an annual appraisal within the expected time frame. They were given protected time to complete their revalidation.

Good

Medical care (Including older people's care)

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Staff met with their line manager every three months for regular 1-1s. This time was used to support learning and development. They could also meet in between, and staff felt managers were visible and had an open-door policy.

Managers made sure staff received any specialist training for their role. Endoscopy nurses received training in cannulation. Oncology nurses attended the required university course and competencies to be able to administer systemic anti-cancer therapy (SACT). They had to complete regular SACT training. This enabled them to administer SACT medication via the intravenous, sub-cutaneous, intramuscular, and oral routes.

Oncology nurses attended specialist conferences to maintain their expertise. They were annual and had been maintained virtually during the pandemic. They provided specialist training to core staff. This was planned training supported by oncology consultants. They also delivered ad-hoc training during quieter periods to ensure staff were supported to develop their skills and knowledge.

Every patient had a named consultant. There was one resident doctor available for the unit. They completed online mandatory training through their employment agency. This included training in advanced life support. The employment agency managed their compliance.

Multidisciplinary working

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

There were effective multidisciplinary teams (MDT) in the endoscopy unit and oncology, in the hospital and externally with GP’s. There was endoscopy representation at regular meetings with the theatre team. They attended the theatre huddle every morning.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. There were monthly meetings between endoscopy and theatre staff. Meetings were minuted. They included agenda items such as overall activity, theatre/endoscopy utilisation, clinical governance reports, staff appraisal and mandatory training.

The team held weekly multidisciplinary meetings to discuss patients they were treating and supporting with cancer. The meetings had continued virtually during the pandemic. They were chaired by a radiologist and attended by the named consultant, specialist nurse(s), lead pharmacist and histopathologist. Named consultants presented an overview of their patient. The group discussed the patient’s diagnosis, test results, pain relief, progress, treatment and general well-being and support. We did not ask to see the minutes of these minutes, but we were told the meetings were effective and that all members were valued and confident to contribute.

All patients had a named consultant. Their first appointment was in out-patients department with their consultant. Patients could also have clinic appointments with specialist nurses in advance of admission for endoscopy procedures or systemic anti-cancer therapy. Specialist nurses worked jointly with named consultants to support patients receiving a distressing diagnosis. They discussed patients together and in advance of appointments. They followed patients up after they received bad news and offered on-going support. They could not offer follow up support for NHS patients after they were discharged from the hospital. However, they liaised with NHS specialist staff to provide effective handover of care.

The specialist nurses helped to prepare patients with cancer for surgical treatment. This helped to provide continuity of care and support. They also provided post-operative support and care.

Good

Medical care (Including older people's care)

The endoscopy and oncology teams discussed patient complaints and feedback related to their speciality and shared any learning to staff via email and a monthly newsletter.

GPs received written information about a patient's endoscopy procedure or systemic anti-cancer treatment. This included what advice the patient had received for their ongoing care.

We were given an example of when staff had received additional training in order to improve multi-disciplinary working. The hospital ran ad-hoc simulation training to create true-to-life learning scenarios that mirrored emergency situations. We read a report from an unannounced resuscitation simulation completed in July 2021. Staff were prepared and understood their role and responsibilities. They worked effectively as a team.

Seven-day services

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

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. A resident medical officer was available seven days a week and provided on call cover for out of hours.

The endoscopy procedures were planned, and sessions were available Monday through Friday from 8am-6pm. Sometimes they extended their hours to ensure patients were not rushed and made a full recovery. If a patient needed to stay overnight, they were transferred to the day ward.

The oncology service was available Tuesday through Thursday. There was out of hours support for patients who were receiving systemic anti-cancer therapy. There was 24-hour cover over seven days a week. The oncology team provided the cover for any patient that had concerns or any adverse effects.

Pharmacy was available Monday through Friday. The hospital had a process for out of hours pharmacy support that staff were familiar with. The hospital operated an on-call system for senior managers seven days a week. Consultants were on call out of hours and seven days a week.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Oncology staff used a specific cancer research consent form (CRUK). This was signed by the patient and the clinician agreeing to the proposed treatment plan, prior to the first treatment. The original copy was filed in the patient's notes and a copy given to the patient. This had to be available prior to every administration of systemic anti-cancer therapy (SACT). A photocopy of the consent had to be given to the patient. Secondary consent had to be obtained before the administration of SACT and signed on the CRUK consent form. The oncology nurse discussed potential adverse outcome and complications of treatments.

Staff made sure patients consented to treatment based on all the information available. Sperm banking or egg freezing was discussed with relevant patients prior to booking treatment, unless their clinical condition dictated otherwise. The pre-assessment nurse discussed the implications on fertility. This included the risks that toxic body fluids contain during intercourse with partners.

Good

Medical care (Including older people's care)

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

Good

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

Compassionate care

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

Patients said staff treated them well and with kindness. A patient who was extremely anxious prior to their endoscopy shared how the caring attitude of staff and effective communication had helped them to relax. This had made them feel able to continue with the procedure.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. They used a specific room to break bad news and for patients in distress in the endoscopy unit.

They were given privacy to change, and they had access to private male and female toilets with call bells. Patients attending for systemic anti-cancer therapy had a private room with ensuite facilities and a call bell. They were asked if they would like a chaperone during consultant appointments and if they had a gender preference.

All oncology and endoscopy rooms had call bells. Staff were alerted to patients who had used their call bell by a light which displayed outside their room. It also flagged on the display panel behind the staff reception desk.

Patient survey results for July- September 2021 reported 97% of responses always had their privacy and dignity respected. These results were not specific to endoscopy or oncology, but overall results for patients who had attended the hospital.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We did not observe any patient interactions, but staff in endoscopy told us how they would try to reduce a patient’s anxiety prior to procedures.

Oncology staff asked patients if they wished for a specific type of service relating to religious, spiritual or cultural beliefs. For example, referral to their hospital chaplain, use of healing crystals, or music requests. 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.

Oncology staff provided holistic assessments and advice prior to patients commencing systemic anti-cancer therapy. For example, they discussed the potential impact of treatment on their sexuality and reproduction. They gave advice and information such as hair care, wig providers, and discussed individual concerns related to self-image and self-esteem. A member of the oncology team was always on call to ensure 24-hour support to patients, including out of hours support.

Good

Medical care (Including older people's care)

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff involved family members and cared for patients in a holistic way. For example, a patient attended for systemic anti-cancer therapy alone. This was because their partner was unable to accompany them at short notice, due to a personal issue. Staff provided additional clothes and toiletries for the patient, arranged a hospital driver to transport them home, and followed up on their partners wellbeing.

Staff supported patients to make advanced decisions about their care. Patients received information to support them in understanding how to manage their condition. For example, they discussed advanced care plans prior to commencing systemic anti-cancer therapy. Oncology patients were given information to help them recognise if they were developing side effects from treatment, and how these should be managed.

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

Good

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

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

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

The endoscopy unit opened in January 2018. It had been upgraded to support the achievement of Joint Advisory Group (JAG), in gastrointestinal endoscopy accreditation. The hospital had achieved JAG accreditation in December 2020.

The oncology service was awarded the Macmillan environment quality mark (MQEM). This is a detailed quality framework, used for assessing whether cancer care environments meet the standards required for people living with cancer.

The MQEM assessed four main areas of the cancer service. These included clear wayfinding for visitors, welcoming and ascetically pleasing reception and waiting areas, and access to private consultation rooms. The assessment also included the user's journey. For example, the cost and availability of parking, how easy it is to get to the facility on public transport, internal facility signposting and flexibility in making appointments.

The assessment looked at access to cancer-specific information and health professionals, choice and range of food available, cleanliness and tidiness of facility. It also assessed the level at which users are involved in the development of services, and how important people's views are considered. The cancer environment created welcoming and friendly spaces for patients. It was designed in collaboration with people living with cancer.

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

Meeting people's individual needs

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

Good

Medical care (Including older people's care)

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Wards were designed to meet the needs of patients living with dementia. Staff used a blue magnet next to their name on the staff board. This was to raise awareness about their additional needs. They used specific resources such as signs and clocks to create a meaningful environment for patients living with dementia.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. The hospital was collating a bank of translators and interpreters. They booked them in advance of appointments and planned admissions, for non-English speaking people. They used a service that offered phone interpretation as well as face to face, sign language, and video calls. Staff also had access to an emergency multilingual phrasebook.

The endoscopy unit had a lift for people unable to use stairs, and there was a lift to the oncology beds on Enbourne ward. They provided level access for patients' if required.

Oncology nurses provided patients with information on discharge, should they have any concerns when not attending for treatment. They gave them information about the signs and symptoms to look out for following systemic anti-cancer therapy, and what they could do to relieve them. They also gave them out of hours contact details in case of concerns.

They used gender-neutral pronouns and referred to transgender people by the name and pronoun that corresponded with their gender identity. This helped staff avoid mistakes such as misgendering someone and helped to maintain inclusivity. The oncologist team gave us an example of how they had supported a transgender patient to provide a procedure to themselves.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff told us they had altered patient menus in response to patient feedback.

Access and flow

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

The number of decontaminated endoscopes and size of scopes received by the hospital enabled the scheduled endoscopy lists to proceed uninterrupted. This met the standards set by the Joint Advisory Group (JAG), on gastrointestinal endoscopy.

The provider's Clinical Commissioning Groups decided to cease monitoring the 18-week referral to treatment at the start of the COVID-19 lockdown in March 2021. This was as the Independent Sector Healthcare mobilised to support the NHS. It was at this point that the standard acute contracts were suspended and a direct contract with NHS England was established. The hospital reported all their activity to NHS England through a portal. This was set up to review their forecasted capacity against the actual activity

Consultants saw patients who were referred by their GP as an outpatient before an endoscopy procedure. They checked they met the admission criteria, assessed patients and discussed a plan of treatment. Consultants undertook endoscopies according to a patient pathway, minimising the time patients waited for treatment and care. Staff planned for the flow of patients

NHS consultants referred oncology patients following diagnosis at an NHS hospital. Patients were seen by their oncologist and then referred to the oncology team with a clinic appointment. Their consultant outlined the proposed treatment plan for the patient.

Good

Medical care (Including older people's care)

Oncology staff on Enbourne ward ensured the patient and consultant were kept informed If there were delays in the administration of treatment. They maintained a record in the patient's notes.

Learning from complaints and concerns

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

Patients were actively encouraged to leave comments and feedback via the company patient satisfaction survey. Complaint forms were available on a central desk on Enbourne ward and in the endoscopy unit. Patient feedback was on display in. This included individual comments, themes and overall results. We did not ask about complaints specific to the endoscopy unit or oncology patients. However, staff explained the complaints process. They would listen to the patients' concerns to try and resolve the issue and seek support from their line manager if needed.

The provider acknowledged all complaints and wrote thank you cards to all patients/the public for raising their concerns. They were logged in order to ensure the investigation and response was managed in line with local policy.

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning was shared with staff through emails and monthly bulletins. Staff gave examples of how complaints had been resolved and used to improve patient care and experience. For example, they made changes to their menus, and they had changed the clocks in patients' rooms, so they did not make noise.

Complaints were discussed at monthly clinical governance meeting and heads of department meetings. The lead for oncology and theatre manager attended these meetings. Lessons learned were shared with staff working in oncology and those working in endoscopy as needed.

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

Leadership

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

The senior management team at the hospital included the executive director and director of clinical services. They were responsible for the day-to-day management and development of the hospital. The endoscopy lead nurse reported to the theatre manager. There was an oncology lead at the hospital and at provider level. The endoscopy lead and oncology nurses felt well supported.

The main service was Surgery. Where arrangements were the same, we have reported findings in the Surgery section.

Good

Medical care (Including older people's care)

Vision and Strategy

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

The vision for the Circle Health Group was to provide high quality, safe and compassionate care for their patients. Their strategy was to focus on four key areas to underpin the creation of a strong foundation for their future success. They developed this plan by listening to people and patients and responding to their needs.

The vision for the Hampshire hospital was to prioritise patients and staff, ensuring a safe environment, whilst preserving an effective and responsive service. Their vision was to be well-led by a professional, caring, and trustworthy culture.

The main service was Surgery. Where arrangements were the same, we have reported findings 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.

All staff we met during our inspection were welcoming, friendly and helpful. We spoke to staff across most grades and various disciplines. They told us they were proud to work for the provider. The oncology and endoscopy staff described healthy working relationships where they felt respected and able to raise concerns without fear. The culture was one of learning, not blame. They were encouraged to be open and honest with service users and staff when things went wrong.

They told us they were most proud of the way they had supported the NHS during the pandemic. Some staff described their teams as ‘feeling like family.’ They were focused on the needs of patients and proud of their accreditation awards.

The hospital had a Freedom to Speak up Guardian (FTSuG). Their role was to support staff who wished to speak up about a concern or issue. They ensured any issues were listened to and provided feedback on any actions or inactions. Their details were advertised in clinical areas.

The main service was Surgery. Where arrangements were the same, we have reported findings 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.

The hospital’s clinical governance committee met monthly. Audit, action plans, training compliance, policy reviews/updates, complaints and user feedback were regular agenda items. The committee had staff representation from clinical areas. The theatre manager was responsible for ensuring issues relating to governance in endoscopy were raised at the clinical governance committee. The quality and risk manager were responsible for ensuring issues related to governance in oncology were raised.

Good

Medical care (Including older people's care)

Leads disseminated information to clinical areas. For example, key information such as lessons learnt, policy updates and patient feedback were highlighted on information boards in clinical areas. This included endoscopy and Enbourne ward. The committee supported safety and quality of clinical care. They ensured staff were able to learn about the quality of the service.

There was a systematic programme of internal and external clinical audit to drive improvement. The hospital used an audit calendar to ensure audits were completed within expected time frames. They completed an action plan if there was non-compliance with any audit standards. The company employed an Authorising Engineer in Decontamination. Their primary role was to provide impartial advice and auditing on all aspects of decontamination in the endoscopy unit. They completed annual, independent audits of their decontamination service to ensure their equipment was safe to use.

There was an endoscopy specific user group at the hospital. This was chaired by a senior endoscopy nurse. Attendees included the clinical lead for endoscopy, clinical service lead, theatre manager, gastroenterologist, infection prevention and control lead, and a dietitian. The meetings were held every three months. Endoscopy staff also held team meetings every three months.

The hospital had a medical advisory committee. They met quarterly and included consultant representation for oncology and endoscopy. They considered and made recommendations to the Board on matters pertaining to the medical staff. This included the appointment or reappointment of all members of the committee.

The main service was Surgery. Where arrangements were the same, we have reported findings in the Surgery section.

Management of risk, issues and performance

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

Staff in the department recorded risks using the hospital's electronic risk management system. They knew what incidents to report, and how to report them. Staff received feedback following any incident reporting.

There was a hospital wide risk register. Risks were categorised as very low, low, medium or high. There were no open risks determined as high on the register. The risks were overarching and not specific to endoscopy. There was one risk related to oncology. It was recorded on 8th August 2019. It was recorded as a risk of contamination of water supply in augmented care areas which included oncology on Enbourne ward. The risk was mitigated by quarterly water testing, calorifiers were replaced and water temperatures being maintained. The risk needed to be reviewed on 29 October 2021.

The Circle Health Group produced a monthly clinical governance, quality and risk bulletin. This included any lessons learnt from investigations to incidents. The bulletin highlighted safety alerts in relation to medical devices. Learning was shared from events and related to specific topics.

The main service was Surgery. Where arrangements were the same, we have reported findings 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.

Clinical staff could access information using a computer with individual login details. This enabled them to access patient information such as referral letters, blood test results, x rays and other investigation results.

Good

Medical care (Including older people's care)

Staff sent discharge letters to GPs. They included the reason for endoscopy procedures, findings, prescribed medication, any medication changes and details of follow up. They also placed a copy of the letter in patients' medical records at the hospital. Staff in oncology sent a letter to the patient's GP detailing systemic anti-cancer therapy.

Staff could access information on the hospital intranet. This included clinical policies and standard operating procedures.

The main service was Surgery. Where arrangements were the same, we have reported findings in the Surgery section.

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services.

Patients were encouraged to leave feedback using a patient's satisfaction questionnaire. They were available in the rooms where oncology patients were treated and in the endoscopy unit. Patient feedback was reviewed at clinical governance meetings. We read the collated results for quarter two of 2021. They were not specific to endoscopy and oncology, but 96.2% of patients said the overall quality of care was very good or excellent, 97% of patients said nursing care was very good or excellent, 98.4% said their consultant was very good or excellent, and 92.8% said their discharge was very good or excellent.

The hospital collected annual feedback from staff and compared the results against other independent providers that were part of their company. Staff were asked to comment on themes such as leadership, personal growth, well-being, and the company. The results were collated and analysed by an independent company. They were reviewed at their monthly clinical governance meetings. An action plan was completed to address issues and maintain good practice. For example, staff at the hospital fed back that their pay did not reflect their responsibility. Management completed a full review of all critical roles and salaries. This included bank staff. Management ensured staff received a fair pay deal.

There was an employee voice forum which included representation form each hospital in the company. The forum was an opportunity for staff to share openly in a safe place.

The hospital had a recognition system for staff called 'Above and Beyond' awards. They also recognised staff for long service through an award system.

The main service was Surgery. Where arrangements were the same, we have reported findings in the Surgery section.

Learning, continuous improvement and innovation

The endoscopy unit achieved accreditation by the Joint Advisory Group on GI Endoscopy (JAG), in December 2020. The aim of the JAG accreditation was to define a high-quality, safe and appropriate endoscopy service, delivered by a highly trained, supported and motivated workforce. The standards were written in consultation with endoscopy services and were underpinned by national policy.

The oncology service was awarded the Macmillan quality environment mark (MQEM). This was a detailed quality framework, used for assessing whether cancer care environments meet the standards required for people living with cancer.

The main service was Surgery. Where arrangements were the same, we have reported findings in the Surgery section.

Good

Outpatients

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

Are Outpatients safe?

Good

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

Mandatory training

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

Nursing staff received and kept up to date with their mandatory training. The service completed training via online or in person depending on the topic. Staff completed 19 mandatory training topics during induction and at intervals of up to three years. This included fire safety, health and safety, information governance and manual handling.

Training compliance was reported as 97% for all staff for all topics. This was above the hospital target of 80%.

Medical staff received and kept up to date with their mandatory training. Mandatory training was largely provided by the consultant's host NHS acute trust. The service ensured compliance with mandatory training through regular reviews of consultant's records which were shared by the acute trusts. Any site-specific training was completed as part of staff's induction and as processes were updated.

The mandatory training was comprehensive and met the needs of patients and staff. Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. Locally managers kept details of training and prompted staff to complete training as per guidance. However, there was also a record held centrally by the Circle group which enabled targeted training per site.

Safeguarding

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

Good

Outpatients

Nursing staff received training specific for their role on how to recognise and report abuse. Staff compliance with safeguarding training was 100%. Staff completed safeguarding adults and children's training in line with local guidance. The level of training varied according to the staff role, for example, administration staff completed safeguarding level 2 training, and clinical staff level 3. All staff had access to an organisational safeguarding lead who could advise on actions to be taken if necessary.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service did not see children or young adults as patients.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff in outpatients reported that they would escalate any concerns if necessary and were able to give examples of how to report concerns internally and externally.

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.

Following the COVID-19 outbreak, the service had changed visiting rules, with patients discouraged from bringing family or friends to appointments, although they could attend following discussion with the team. Staff discussed guidance for COVID-19 testing for patients and any visiting relatives at pre-admission appointments or at pre-appointment booking calls.

Staff explained that patients attending the service were required to complete COVID-19 testing and remain isolated prior to any procedures. This process ensured that if they were admitted for a procedure, they were COVID-19 free.

On arrival to the centre, patients were encouraged to sanitise their hands and use a clean face mask. These were provided at the main entrance and reception staff made sure to respectfully challenge visitors and patients if they were not following the guidelines. All staff and patients were seen to be wearing face masks whilst in the centre.

Clinical areas were clean and had suitable furnishings which appeared clean and well-maintained. All areas were visibly clean and tidy.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We reviewed records for the previous three months. Cleaning was completed regularly and recorded on checklists in multiple occupancy areas. We also saw that clinic treatment rooms were cleaned at the end of each clinic by staff.

The service performed well for cleanliness. Cleaning audits were completed at regular intervals and we saw that that all infection control and prevention audits showed compliance over 94% and in line with target. Other environmental audits such as the personal protective equipment assurance audit and sharps audits showed compliance over 95% for quarter one and quarter two in 2021, which was above the target.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw that staff wore PPE in line with guidance. Face masks were worn throughout appointments and all visitors were requested to wear face masks unless they were medically exempt. There were face masks and PPE available on entry to clinical areas, and hand sanitiser located regularly throughout the site. Staff prompted visitors to sanitise their hands.

Good

Outpatients

All specialist equipment was cleaned by trained clinical staff. Staff cleaned equipment after patient contact and labelled with 'I am clean' stickers to show when it was last cleaned. We saw that all equipment was cleaned using sanitiser or products in line with guidance.

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 environment had been designed specifically to meet the needs of the service. The centre was easily accessible with adequate car parking for a large number of visitors. The reception had staff available who directed visitors to the area of their appointment.

Staff carried out daily safety checks of specialist equipment. We saw checklists for equipment in all treatment rooms. These were checked and signed by the day's staff. Staff told us they were able to access replacement equipment as necessary.

Resuscitation equipment was easily accessible, and we saw that this was checked daily and compliance audited. Hospital data showed that resuscitation equipment had been checked 100% between April and October 2021.

The service had suitable facilities to meet the needs of patients' families. We were told that patients were able to be accompanied, however, where possible this was discouraged due to COVID-19 and social distancing. There were adequate waiting areas which could be used by accompanying persons whilst the patient was seen in a treatment room. All areas were wheelchair accessible.

Staff disposed of clinical waste safely. Waste was removed from clinical areas at regular intervals.

Assessing and responding to patient risk

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

Staff responded promptly to any sudden deterioration in a patient's health. Patients attending the department were generally fit, attending for an outpatient's appointment or consultation. This meant that patients did not routinely have clinical observations performed. This depended on the type of clinic appointment being undertaken and clinical preferences.

When clinical observations or risks assessments were required, staff completed them using a recognised tool, and reviewed them regularly, including after any incident. Staff used the National Early Warning Score (NEWS2) tool to monitor clinical observations. On arrival to the department, those patients requiring assessment, were reviewed by a nurse or support worker, who took baseline clinical observations including blood pressure, pulse rate and temperature. These were used to inform decisions made about the patient's clinical condition and plan their treatment.

Staff knew about and dealt with any specific risk issues. At assessment, patients were monitored for risks that may affect their treatment or recovery. For example, those patients with past medical histories of blood clots, were assessed for anticoagulant therapy to prevent re-occurrence post treatment. Venous thromboembolic (VTE) assessments were completed on all patients as part of the preparation for surgery.

Good

Outpatients

All patients who planned to undergo surgery, or a procedure, were seen by the pre-admission clinic to obtain baseline observations and blood results prior to attending for their surgical procedure. Patients were categorised according to risk. Those deemed high risk were not usually treated at the hospital with arrangements being made with the local acute hospital for their treatment. Lower risk patients were seen by the pre-admission nursing team, the consultant and the anaesthetist. Appointments were designed to provide ample time for discussion about treatments, potential risks and side effects.

Patients undergoing simple procedures within outpatients were assessed by the consultant, supported by the nurse and healthcare assistant and prepared for the treatment. This could include clinical observations, blood testing or swabbing. All results were reviewed prior to treatments commencing.

The service had access to external mental health liaison and specialist mental health support. The service did not routinely provide treatment to patients with known mental health conditions, although staff knew how to access support if there were any concerns. We were given an example of a patient with a mental health condition who was referred to the service for a clinical procedure. Staff reported that the patient would normally have been treated in the acute hospital, but with support from the mental health team, they managed to provide care at the service, preventing an acute admission to hospital.

Staff shared key information to keep patients safe when handing over their care to others. Once patients had been seen in clinics, information was shared with the rest of the hospital teams who would be responsible for completing the patients care pathway.

Staffing

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

The service had enough nursing and support staff to keep patients safe. We saw that staff were allocated to clinics to ensure that patients and doctors had access to support as necessary. When more complex appointments were scheduled, additional staff were provided.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. Clinics were planned in advance so staffing could be arranged. Any last minute changes were discussed to ensure the correct level of staffing was available.

The manager could adjust staffing levels daily according to the needs of patients. The number of nurses and healthcare assistants matched the planned numbers. We saw that the numbers of staff on duty were as planned.

The service had low vacancy rates. Data for July to September 2021, showed that there were two vacancies within the service.

The service had no sickness reported for clinical staff from July to September 2021.

Good

Outpatients

The service had low rates of bank (10%) and agency nurses (12%). Where possible, they limited their use of bank and agency staff and requested staff familiar with the service to ensure consistency. Managers made sure all bank and agency staff had a full induction and understood the service. We were told that agency staff followed the same induction process as new members of permanent staff. At the time of our inspection the department had no agency staff, and a low number of bank staff.

Medical staffing

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

The service had enough medical staff to keep patients safe. Consultations and appointments were arranged according to the doctor's availability. Consultants would inform the hospital of when they were available for clinics and then appointments were scheduled accordingly. Some consultants maintained regular clinics which meant that the booking team were able to plan appointments well in advance. Others provided smaller, less frequent clinics, which would be slotted into the calendar as available. We saw that medical staffing matched the planned number. Staff reported that there were no occasions where clinics could not be accommodated.

Following acceptance into the service, consultants worked under practising privileges. The majority of doctors also worked at nearby NHS acute or specialist hospitals and completed training and revalidation through their host organisation. The service ensured compliance with these as part of annual reviews.

Records

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

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

Records were held on site and collected prior to any appointments to ensure they were available for the consultation. Staff reported that notes were always available for appointments.

Records were stored securely. We saw that notes were not left in any public areas. Patient notes were transported between departments securely and not left unattended. Nursing staff told us that they would place patients notes in consultation rooms prior to their appointment. Doctors clarified patients details prior to commencing the appointment.

Clinic lists were held at the reception desk and names crossed off when arriving and when entering consultation rooms to keep track of which patients had been seen. All lists were held in files at the reception desk to prevent unauthorised access.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We reviewed seven prescription charts. These were complete and in line with national guidance. The majority of medicines used were local anaesthetics which were used for some clinical procedures. These were stored securely and checked in line with best practice when used.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Patients medicines were discussed at most clinic appointments. Any changes to medicines were explained.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicines were stored in the treatment room which was secure at all times. We saw that the temperature of the treatment room was monitored, and data was recorded in line with national guidance.

Staff followed current national practice to check patients had the correct medicines. All medicines were checked by two practitioners prior to any administration.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Safety alerts were also escalated through safety briefing and huddles.

Incidents

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

Staff knew what incidents to report and how to report them. The service used an electronic reporting tool which was accessible to all staff. Hospital data showed that incidents were reviewed and investigated in a timely manner. We reviewed five incidents.

Staff raised concerns and reported incidents and near misses in line with provider policy. We saw that there were a variety of incidents reports which included actual and near misses. All incidents detailed actions taken in response and resolution.

The service had not recorded any never events in the past 12 months. Managers shared learning with their staff about never events that happened elsewhere. We were given examples of how incidents and their findings had been shared across the site, hospital and wider organisation. There were flash reports at daily huddles which outlined any actions that needed completion.

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. Although staff reported that there had been no serious incidents within the department, they were familiar with duty of candour and knew how to apply it.

Staff met to discuss the feedback and look at improvements to patient care. Staff attended team meetings and discussed how services could be improved. When attendance at team meetings was not possible, key information was shared through emails or newsletters. We saw a variety of media used across the department which all referred to learning from incidents and improvements needed for patient care.

Good

Outpatients

Are Outpatients effective?

Inspected but not rated

We did not previously rate effective. In accordance with our current methodology we do not rate effective for Outpatients.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. 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, such as The National Institute for Health and Care Excellence (NICE) guidelines. We reviewed a number of policies and saw that these reflected best practice and were in date. Clear review dates were set and there was a robust process for ensuring policies were reviewed.

In addition to policies, the service had a number of standard operating procedures (SoPs) which were all based on current guidelines and reviewed regularly. Policies and SoPs were accessible in paper copies (for key items) or via the intranet. Staff told us they were encouraged to use electronic versions as reference as these were the most up to date and prevented old information being used. Heads of department would replace any policies or SoPs in paper format when they were updated.

Staff we spoke with knew about the Mental Health Act and the Mental Capacity Act and had completed dedicated training. Staff were able to provide examples of supporting patients with complex mental health needs, and also gave us clear examples of discussing, obtaining and documenting consent.

Staff audited practice and monitored outcomes to ensure staff followed guidance.

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

Patients received information to advise them about timescales for when they could eat and drink in advance of any invasive procedures. This was provided in the appointment letter. We observed reception staff informing patients of any preparation required before their procedure in relation to food and drink.

Water cooler machines were available in the waiting rooms for patients and those who accompanied them.

There was a café available for patients to use in the hospital. The menu included diverse options to cater for the patients' cultural and religious needs.

Pain relief

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

Good

Outpatients

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff did not routinely administer pain relief in outpatients, unless patients were undergoing a procedure, when some pain relief medicines may be given. Pain was discussed at most appointments, and actions taken appropriately. Staff had materials to assess pain for patients with communication or learning difficulties. Patients received pain relief soon after requesting it.

Patients with ongoing pain needs could be referred to pain teams if necessary, for ongoing advice or treatment.

Patient outcomes

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

Managers and staff used the results to improve patients' outcomes. Actions were clearly attributed to audit results and trends were monitored to ensure an improvement in performance.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. We reviewed audit results for August 2021 which showed 98 to 100% compliance in the World Health Organisation (WHO) five steps to safer surgery checklist audit, and 100% compliance in the hand hygiene audit.

Managers shared and made sure staff understood information from the audits. We saw that audit results were discussed across all areas of the service. This included at departmental meetings, performance review meetings and as part of the organisational performance monitoring. A dashboard was displayed detailing performance.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff were skilled to manage the workload and used competencies to confirm skills.

Managers gave all staff a full induction tailored to their role before they started work. There was a robust induction process which included orientation and escalation processes to ensure staff were familiar with the environment and processes used by the service. Agency staff completed the same induction process to promote safety and consistency.

Managers supported staff to develop through yearly, constructive appraisals of their work. All staff told us that they had completed an appraisal within the last year. The appraisal rate for the service was reported as 100%.

Medical revalidation was completed at the consultant's host organisation. Consultants were responsible for ensuring that revalidation information was shared with the service, and this was tracked to ensure compliance. Any staff member with out of date revalidation was not permitted to work until it had been completed. This was monitored through yearly appraisal processes, and also discussed during regular medical advisory and governance meetings.

Consultants capabilities and performance was monitored through the medical advisory committee (MAC) and any concerns were flagged and addressed accordingly. Consultants were not permitted to complete any procedures which they had not been deemed competent to complete. The MAC approved all procedures prior to them being completed within the service.

Good

Outpatients

Managers made sure staff attended team meetings or had access to full meeting notes when they could not attend. We saw meetings were well attended by staff and minutes were sent electronically to all staff to enable access.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff reported they were given time and were supported to develop. Managers made sure staff received any specialist training for their role. We were given examples of how staff had attended additional training to develop.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care. We were given examples of patient pathways and how they included MDT meetings and discussions. Staff told us MDT meetings were inclusive, and all opinions were taken into consideration when planning care.

Patients could see all the health professionals involved in their care. There were boards introducing the team in the waiting areas.

Staff worked across health care disciplines and with other agencies when required to care for patients. We were given examples of where patients had been assessed as not suitable for their planned procedure at the hospital and how these patients were discussed with peers from the local acute hospital trusts. Staff also told us how other agencies and speciality staff could be accessed to gain support for more complex patients.

Seven-day services

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

Staff could call for support from doctors and other disciplines. The service was available from 7.30 am to 8.30 pm Monday to Fridays and 9 am to 12 pm on Saturdays.

Staff told us they were as flexible as possible to meet the demands on a service and to meet patients' needs and availability. Patients attending an appointment could also attend the diagnostic imaging department for further tests, and staff completed blood testing and swabbing at the same time to prevent repeated attendances.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas. We saw that patients were regularly offered support to live healthier lives. This included signposting to smoking cessation and prompts for reducing alcohol consumption. There were numerous posters throughout the department, including the hydro-pool area where we saw four posters to help patients undergoing physiotherapy better understand the steps and risks involved.

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.

Good

Outpatients

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The service audited consent forms to ensure that they were completed fully, detailing potential risks, the procedure planned and that they were signed and dated. Consent was discussed within outpatient appointment for treatments or procedures completed within the department.

Staff clearly recorded consent in the patients' records. Consent forms for all procedures completed in outpatients were completed at the time and reflected discussions of risk. Staff were able to describe conversations and processes for ensuring consent was gained prior to treatments.

Are Outpatients caring?

Good

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

Compassionate care

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

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 were told that appointments were designed to enable sufficient time for discussion and questioning and patients verified that staff used this time to answer questions. This was also reflected in the patient feedback we reviewed.

Patients said staff treated them well and with kindness. We spoke to four patients who felt the level of care they received was 'impressive'.

Staff followed policy to keep patient care and treatment confidential. All information was kept securely, with medical notes in rooms with doctors and any expected patient lists, covered in files. All discussion were held in rooms which prevented unauthorised persons overhearing key personal information.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgemental attitude when caring for or discussing patients with mental health needs. We were given examples where patients' past medical history of a mental health condition was discussed sympathetically, resulting in consideration for a procedure at the hospital. Staff told us that the patient would have been transferred to an acute hospital for their procedure if staff had not identified coping mechanisms to enable the patient to be safely treated on site. The reported outcome was positive for the staff and patient.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. The service provided care and treatment for a diverse population and employed staff from a number of different cultures or religions. Staff expressed that they were able to meet the demands of patients through understanding of their needs from discussions. Staff gave us examples of supporting patients who required female doctors, as well as alternative foods, such as halal, as needed.

Good

Outpatients

Emotional support

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

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

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff told us how they supported a patient who had to be admitted unexpectedly. Their next of kin was not present as planned. Staff arranged ad-hoc transport for the patient to go home so they could see their next of kin and ensure they were okay, and also pick up some essential items for their stay.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff told us that they explained treatment and plans clearly with patients and / or their relatives. Staff extended appointments where necessary to ensure patients fully understood what was happening.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff used plain language to ensure patients understood what was happening. Patients we spoke with reported clear communication, and we observed staff being friendly and considerate when speaking to patients and their relatives.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Information was collected following appointments about patients' experiences. This was used to make any changes to the service. Staff told us about complaints received regarding communication and clarification of costs and that a new system had been implemented to stop invoices going to patients that had already paid.

Patients gave positive feedback about the service. We saw that feedback was largely positive, with 96.2% detailing that the service had been 'excellent'.

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

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the changing needs of the local population. We reviewed the up-to-date Equality and Diversity policy, and found it was detailed, followed national law and guidance, and contained inclusive language. We also reviewed equality impact assessments that the service had in place for their internal policies and found them to be thorough and accurate.

Good

Outpatients

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. Patients attending the clinic were able to see other services while attending the centre. Blood testing, swabbing and diagnostic imaging were available on site along with a pharmacy which provided prescription and non-prescription medicines.

Facilities and premises were appropriate for the services being delivered. Consultation rooms were large enough to enable patients and clinicians to attend. Each room was screened by curtains from any escorts. Chaperones were also offered for any patient attending appointments on their own, who may require a physical examination.

Managers monitored and took action to minimise missed appointments. We saw that patients were sent reminders of appointments and were able to make appointment to suit their schedule. Missed appointments were minimal.

Managers ensured that patients who did not attend appointments were contacted. Staff gave us several examples where, following a missed appointment, the team would contact patients to identify why they had missed their appointment and offer an alternative slot.

The service relieved pressure on other departments when they could treat patients in a day. The service provided some clinical procedures, which were planned in advance to prevent repeated attendances. Staff told us that patients usually attended a consultation appointment and were then offered a date and time for their procedure to be completed within one week. This enabled patients to prepare for their tests.

Meeting people’s individual needs

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

Staff gave us several examples of supporting patients with protected characteristics. Protected characteristics according to the Equality Act 2010 are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. Staff we spoke with displayed knowledge and understanding of the training on equality and gave examples showcasing how they applied this learning.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. There was a coding system where the “dragonfly” symbol was used to highlight a patient with dementia, both in care notes, and on the ward dashboard. All staff we spoke with had completed their dementia training and were familiar with AIS (Accessible information standards).

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. All staff we spoke with gave us examples of supporting these patients. All clinic and treatment rooms were suitable for use by patients attending who required walking aids. There were low level reception desks, and a lift for use. Public toilet facilities were available for those requiring walking aids or wheelchairs, and there was ample disabled parking close to the entrance.

The service had information leaflets available in languages spoken by the patients and local community. The department had piloted a dedicated translation tool with summaries of procedures available in 22 languages. This was then implemented across the hospital. Staff we spoke with were aware of this tool and knew how to access it. Patients we spoke with told us staff had offered this to them.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. All staff we spoke with gave us examples when they used interpreting services and demonstrated they knew how to use them when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff we spoke with told us they discussed these aspects with patients and made efforts to accommodate all these needs.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed time-frames and national targets. We were told that once a patient had attended their outpatient appointment, and preoperative assessment, admission to hospital was usually planned within a week. Procedures could be changed according to the doctor's availability and in line with the patients plans. Patients were allocated an appointment as soon as they were referred to the service. Staff we spoke with gave us examples of how they tried to suit the patients' needs and availability. All patient feedback we obtained and reviewed indicated satisfaction with waiting times.

Managers worked to keep the number of cancelled appointments to a minimum. Staff told us of two occasions in the past six months when a clinic had been cancelled due to changes to the consultant's availability.

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. We saw cancelled clinics were rare and patients in these exceptional situations were moved to another suitable date and time. Consultants either emailed or called the hospital to cancel lists. Did not attend (DNA) patients were recorded on the tracker which staff could access.

Clinic waiting times were closely monitored. When a consultant was running late, staff called patients to advise. Consultants made efforts to reduce the impact on patients during the course of the clinic.

Managers and staff worked to make sure that they started discharge planning as early as possible. Discharge plans would be discussed as part of the preparation for theatre, with staff informing patients of the expected number of nights in hospital, recovery period and any impact on their well-being. For example, patients attending for knee surgery, were informed of the follow up appointments and need for physiotherapy following discharge from hospital, prior to attending for the procedure.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas. We saw patient feedback forms available in several areas of the department. Additionally, there were many posters with information on how to provide feedback electronically, on the website.

Good

Outpatients

Staff understood the policy on complaints and knew how to handle them. All staff we spoke with were aware of the complaints policy and reported discussing patient and carer feedback. We reviewed complaints data from March to August 2021 and found that 66.3% had been upheld. The service followed the internal complaints policy and targets, as well as national guidance.

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

Staff told us that the main trend in the past six months related to not setting expectations or clarifying payment costs. The service implemented a new procedure, sending all this information to patients prior to their initial appointments, so as to include all prospective costs. We looked at minutes of clinical governance and departmental meetings and saw that they included learning from complaints.

Are Outpatients well-led?

Good

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

Leadership

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

The hospital had a clear management structure in place with defined lines of responsibility and accountability.

The hospital was led by a senior management team consisting of an executive director (ED), a director of clinical services, a quality and risk manager and an operations manager.

The Outpatients Clinical manager was very visible and accessible, and staff reported they felt comfortable in escalating concerns to any senior member of staff. They also reported they felt confident that action would be taken when they escalated concerns.

Staff told us the leadership team were focused on ensuring patient safety, and as a result was reviewing pathways and services.

Staff spoke positively of the service and senior leads. We saw positive interactions between staff which demonstrated that there was regular contact between staff groups and levels. Leads and senior leads knew staff by name and engaged in conversations which demonstrated that they knew their team well. For example, we saw staff asking how family members were and thanking them for work that had been completed.

Service leads and senior leads had open door rules and encouraged staff to “drop in” if they wanted to talk about anything.

Good

Outpatients

Vision and Strategy

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

The service followed the Circle Health Group clinical strategy which had been reviewed in 2021 and was focused on "providing high quality, safe and compassionate care" to patients. There were three key areas of focus which included clinical quality, patient safety and medical and clinical governance. All staff we spoke with could refer to the strategy and spoke about the drive to improve patient safety and experience.

Culture

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

Staff we spoke with were positive about their roles and enjoyed working for the organisation.

Staff were positive about their jobs and worked collaboratively with their peers. We saw that staff adopted practices to support each other when activity increased ensuring tasks were completed in a timely manner. There was a full team focus, with nurses and healthcare assistants working collaboratively with reception staff, domestic and other non-clinical staff to communicate about patients and caseloads.

Staff felt comfortable raising any concerns and staff generally felt that something would happen if they escalated concerns. Staff gave us examples of when they felt unhappy and raised concerns, which their immediate managers took into account and acted on. Staff told us they were not discriminated against after raising concerns.

Staff also felt encouraged to develop and told us they were given opportunities within the organisation or externally if possible, to develop new skills or gain knowledge.

The service participated in the heard staff annual surveys. Data from the staff survey published in March 2021 showed that outpatient's staff were largely positive and had improved since the 2020 survey. The survey result showed that staff were proud to work for the service and felt positive about succeeding together.

The service promoted equality and diversity and it was part of mandatory training. Managers and staff promoted inclusive and non-discriminatory practices. The provider had committed to meeting racial equality standards and had completed a WRES (Workforce Race Equality Standard) report for 2019 and 2020.

Governance

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

There was a robust governance structure. There was a variety of meetings which enabled the escalation of any issues or concerns to the senior leadership team. We saw that each meeting was clearly minuted and actions recorded. There was a clear pathway of escalation to the senior leadership team and the wider Circle Group organisation. The reporting structure enabled oversight of all services and a standardisation of information.

Good

Outpatients

Outpatients meetings took place every morning, and included discussions around incidents, learning, improvement and future vision, as well as additional training needs from staff. Staff told us the director of clinical services was always free and available to support as and when needed. Additionally, staff reported good visibility and collaboration with the quality and risk manager whenever they needed to escalate. Performance review meetings were held quarterly and attended by the senior leadership team and a selection of consultants from each speciality. The meetings would review performance and discuss any safety issues, any requests for new membership or new procedures.

Policies and forms used by the service were reviewed, updated and replaced at regular intervals. The governance team had oversight of all templates used and when they were due for review. All policies and templates were reviewed and approved prior to use.

The governance lead had oversight of all risks, incidents, complaints, as well as operational governance such as policy reviews. The team produced a quarterly performance report which covered all areas of governance including, compliance with targets and audits, details of serious incidents and actions taken, incidents and near misses reported, infection control rates, and patient satisfaction scores. The reports were discussed at the governance and performance meetings, and staff were held to account by the senior leadership team.

The governance team also produced governance messages weekly. We saw that these covered any relevant topic and were used to either promote something, such as a new policy or training, or to share information, such as accessing emails, and accessing policies. Staff within the service were familiar with the reporting framework and attended meetings when necessary to keep informed.

Management of risk, issues and performance

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

There was an audit programme which monitored compliance against standards. We saw that there were several outpatient specific audits which included physiotherapy documentation, surgical safety checklist- observational audit, environment checks and infection prevention and control. There were clear criteria for each audit and staff were expected to complete a specified number of reviews each month. We were told audit results were reviewed by heads of department and the deputy/director of clinical services at regular intervals.

The outpatients department held a local risk register, alongside the overall hospital register. Risks were graded according to their potential harm. Any significant risks were added to the hospital risk register, whereas low risks were managed by the local teams. Local risks included manual handling risks for staff. Staff we spoke with were familiar with the risks.

Heads of department (HoDs) were held responsible and accountable for their department. We were told that HoDs had regular performance meetings with the senior leadership team to review performance, compliance, staffing, and any concerns.

Good

Outpatients

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.

Information systems enabled staff to complete appropriate analysis of data and compare results with peers and identify trends. Staff reported that data was of a good quality and enabled them to complete the tasks in hand.

Staff knew how to escalate information internally and externally and felt that systems were in place to facilitate that.

Staff completed general data protection regulation (GDPR) and information governance training and were familiar with how to maintain information security.

Engagement

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

The service completed monthly satisfaction surveys. Data from the second quarter of 2021 showed that 89% of patients attending the outpatient services had a good or very good experience, which was in line with the organisations average. The same survey showed that 98% of patients would choose the hospital again.

The department had a closed social media group which staff used to share information. Staff reported this was a good way of catching up with any changes or with seeking support or cover. The service also used regular emails to keep staff informed.

Where possible, the service worked with nearby organisations to ensure patient care and treatment. On occasion, staff had referred to local services to gain support for patients or refer to them due to being inappropriate for the service.

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.

There was a focus on continuous learning and improvement. The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.

Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury Surgical procedures Diagnostic and screening procedures Family planning services	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider must improve governance processes in critical care so there is assurance that the service is managing risk and delivering evidence-based care and treatment. (Regulation 17(2)(a)(b))