The Berkshire Independent Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from 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?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Summary of findings

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

The Berkshire Independent Hospital is operated by Ramsay Health Care UK Operations Limited . The hospital has 35 beds. The service was opened in 1993. Facilities include 35 en-suite rooms, three operating theatres, X-ray, outpatient services and diagnostic facilities.

The hospital provides surgery, medical care including endoscopy, outpatients and diagnostic imaging. We inspected surgery, endoscopy, outpatient and diagnostic facilities. The hospital does not provide care to children.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 25 February 2020.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

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

We found areas of good practice:

- The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- The service controlled infection risk well and staff followed their procedures and national guidance to protect patients from the risk of infection on the wards and in the operating theatres.
- 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.
- Staff assessed risks to patients, developed care plans to manage risks and kept good care records.
- The staff managed medicines well. Staff assessed patients' pain and gave them pain relief when they needed it.
- Staff provided support to patients to meet their dietary needs. Patients were offered food choices and gave them enough to eat and drink,
- 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 had rooms allocated to specialties which were prepared with appropriate equipment for investigations or treatment. This enabled equipment to be easily accessible to reduce waiting time.
- 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 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

- Physiotherapists worked collaboratively with outpatient departments and ward staff to ensure patients received a timely and streamlined service.
- All patients were seen within the national recommended referral to treatment times which minimised the risk of patient harm.
- 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.
- Staff 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.
- 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.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders 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.

We found areas of outstanding practice:

- The hospital had developed the role of a mental health support nurse to provide support for patients living with dementia, patients with learning difficulties and supporting the mental health of staff and patients.

We found areas of practice that require improvement:

- There were carpeted areas at the service which may pose infection control risks as spillages including body fluids may not be adequately cleaned.
- The external clinical waste storage facility was not secure and may pose risk of unauthorised access to it.
- The asset register of the radiation protection supervisor did not include all equipment such as those used in the operating theatres.
- The equipment fault log in radiotherapy was not reviewed and up to date.
- The diagnostic reference levels exposure factor charts were not readily accessible to staff in the diagnostic imaging department.

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Name of signatory

Nigel Acheson

Deputy Chief Inspector of Hospitals South on behalf of the Chief Inspector of Hospitals.

Overall summary

Summary of findings

The Berkshire Independent Hospital is operated by Ramsay Health Care UK Operations Limited . The hospital opened in 1993. It is a private hospital in Reading Berkshire. The hospital primarily serves the communities of Berkshire and the surrounding areas. The hospital also accepts patient referrals from outside this area. The hospital treated insured patients, those who were self-funded and NHS patients commissioned by East Berkshire, Oxfordshire and Berkshire West Commissioning groups.

The hospital has had a registered manager in post since December 2018. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage a service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how a service is managed.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care (including older people's care)	Good	Medical care services were a small proportion of hospital activity. The main service was Surgery. Where arrangements were the same, we have reported findings in the main service section. We rated this service as good because it was safe, effective, caring, responsive and well led.
Surgery	Good	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. Staffing was managed jointly with medical care. We rated this service as good because it was safe, effective, caring, responsive and well-led.
Outpatients	Good	Outpatient care services were a small proportion of hospital activity. The main service was Surgery. Where arrangements were the same, we have reported findings in the main service section. We rated this service as good because it was safe, caring and responsive and well led. We currently do not rate effective for outpatient services.
Diagnostic imaging	Good	Diagnostic imaging services were a small proportion of hospital activity. The main service was Surgery. Where arrangements were the same, we have reported findings in the main service section. We rated this service as good because it was safe, caring and responsive and well led. We currently do not rate effective for diagnostic imaging services.

Summary of findings

Contents

Good

The Berkshire Independent Hospital

Services we looked at surgery, medicines, outpatient and diagnostic services.

Summary of this inspection

Background to The Berkshire Independent Hospital

The hospital provides care and treatment to adults which included general and orthopaedic surgery, gastroenterology, urology, gynaecology, eye surgery and pain services. There are three operating theatres and two of these have laminar flow (a system of circulating filtered air to reduce the risk of airborne contamination).

The hospital has one ward and is registered to provide the following regulated activities:

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

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, and four specialist advisors with expertise in surgery, endoscopy, outpatient and diagnostic imaging.

The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Why we carried out this inspection

We inspected this service using our comprehensive inspection methodology to assess how the hospital was meeting the needs of people using the service. We carried out the announced part of the inspection on 25 February 2020.

How we carried out this inspection

During the inspection, we visited the ward, outpatient and diagnostic services, the endoscopy unit and the operating theatres. We spoke with 11 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with six patients and their relatives. During our inspection, we reviewed 12 sets of patient records.

Information about The Berkshire Independent Hospital

The hospital has 35 beds and is situated in Reading. Facilities include 35 en-suite rooms, three operating theatres, X-ray, outpatient services and diagnostic facilities.

The hospital provides surgery, medical care including endoscopy, outpatients and diagnostic imaging. We inspected surgery, endoscopy, outpatient and diagnostic facilities. The hospital does not provide care to children.

Summary of this inspection

The hospital has been inspected six times since the service was registered, and the most recent inspection took place in March 2019 which found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity (November 2018 to December 2019)

- In the reporting period November 2018 to December 2019. There were 4724 inpatient and day case episodes of care recorded at the hospital; of these 65% were NHS-funded and 35% other funded.
- 9% of all NHS-funded patients and 28% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 344 upper and lower gastro intestinal procedures in the endoscopy unit, in the same reporting period.
- There were 17,542 outpatient total attendances in the reporting period; of these 32% were other funded and 68% were NHS-funded. These included outpatients follow up visits.
- There were approximately105 consultants which included surgeons, anaesthetists, physicians and radiologists who worked at the hospital under practising privileges. Two regular residents' medical officer (RMO) worked on a two weeks rota. As of April 2019, the service employed 26 registered nurses,11 care assistants, six operating theatre practitioners, nine allied health professionals, two pharmacists and 60 administrators and support service staff, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the head of clinical services (matron).

Track record on safety:

- there were no never events
- Clinical incidents 177 no harm, 49 low harm, 5 moderate harm, no severe harm, no death.
- No serious injuries.

No incidents of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),

No incidents of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)

No incidents of hospital acquired Clostridium difficile (C. Diff)

No incidents of hospital acquired E. coli

The service received 25 concerns/ complaints in the reporting period July to December 2019.

Services accredited by a national body:

- Joint Advisory Group on GI endoscopy (JAG) accreditation

Services provided at the hospital under service level agreement:

- Pathology and histology
- Interpreting services
- Laser protection service
- Maintenance of medical equipment
- RMO provision
- Clinical and or non-clinical waste removal
- Cytotoxic drugs service
- Blood products

What people who use the service say

The patients were positive about the care and treatment they received. They told us the staff were caring and compassionate and always respected their privacy and dignity when providing care. Patients said they were provided with clear information in order to make an informed choice regarding their care and treatment. They said staff involved them and their families in their care as appropriate. Patients who were paying for their treatment privately, told us that the costs and payment methods available had been discussed with them before their admission.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

Are services safe?

Our rating of safe stayed the same. We rated it as **Good** because:

- Staff completed and updated risk assessments for each patient to minimise risks. Staff identified and acted upon patients at risk of deterioration.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe 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.
- 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 service-controlled infection risks well. The service used systems to identify and prevent surgical site infections. Staff used equipment and controlled measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- The service 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.

However, we also found the following issues that the service provider needs to improve:

- The service should follow good practice guidance and keep the clinical waste bins in the grounds locked to minimise risks of unauthorised access to sharps and other clinical waste.
- There were carpeted areas at the service which may pose infection control risks as spillages including body fluids may not be adequately cleaned.

Are services effective?

Good

Are services effective?

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

Summary of this inspection

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.
- Staff protected the rights of patients' subject to the Mental Capacity Act 2005.
- The endoscopy service had been accredited under Joint Advisory Group on gastrointestinal endoscopy (JAG) clinical accreditation scheme.
- 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 gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service adjusted for patients' religious, cultural and other needs.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- 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.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Are services caring?

Good

Our rating of caring improved. We rated it as **Good** because:

- Staff treated patients with compassion and kindness respected their privacy and dignity and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff knocked before entering patients' bedrooms and when patients were in treatment areas and consulting rooms.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Are services responsive?

Good

Are services responsive?

Summary of this inspection

Our rating of responsive stayed the same. We rated it as **Good** because:

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

Are services well-led?

Good

Our rating of well-led stayed the same.We rated it as **Good** because:

- Leaders had the integrity, 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 service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff 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.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and

Summary of this inspection

issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

- The service 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.
- 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.
- 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.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Good	N/A	Good	Good	Good	Good
Diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Medical care (including older people's care)

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

Are medical care (including older people's care) safe?

Good

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

The service had a stand-alone endoscopy unit on the ground floor. It consisted of a procedure room and a two bedded recovery area. The endoscopy service had received the Joint Advisory Group on gastrointestinal (GI) endoscopy (JAG) accreditation. The JAG accreditation scheme is a patient-centred scheme and based on the principle of independent assessment against recognised standards. The scheme was developed for all endoscopy services and providers across the UK in the NHS and independent sector.

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

Mandatory training

The service provided mandatory training in key skills including basic life support training to all staff. Managers monitored and reported on compliance with training rates, ensuring there were plans in place to ensure everyone completed it.

The service had processes which were followed, staff received and kept up-to-date with their mandatory training which included core topics such as infection control, moving and handling, dementia care, safeguarding, and intermediate life support. The data received form the service showed staff had achieved between 90 to 100% compliance with mandatory training.

The service had doctors and anaesthetists who worked under practicing privileges. The granting of practising privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinics. They were required to provide evidence from their current NHS role of their compliance with mandatory training. This information was recorded in the individual staff 's file that we viewed during our inspection.

For our detailed findings on mandatory training, please see the Safe section in the Surgery report.

Safeguarding

Staff and leaders 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 service had effective systems to support the staff in raising safeguarding concerns. Safeguarding referral forms were available and staff knew how to access and use them.

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

For our detailed findings on safeguarding, please see the Safe section in the surgery report.

Cleanliness, infection control and hygiene

Good

Medical care (including older people's care)

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

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed guidelines such as bare below the elbow procedures were followed in clinical areas. Staff adhered the five moments of hand washing in line with the world health organisation (WHO) protocols to prevent the spread of infection. Hand wash basins were available in the clinical room and recovery area.

There was a clear clean to dirty pathway for the management of endoscopes. The endoscopes were cleaned manually prior them being sent for decontamination. There was a washing sink and a rinsing sink as well as the washer machine. Endoscopes cleaning included brushing with a single-use cleaning device, rinsing and exposure of all external and accessible internal components to a low-foaming detergent known to be compatible with the endoscope. The scopes were sent to be decontaminated in appropriate trays and packaging.

Staff kept full scope tracking and traceability records. They indicated each stage of the decontamination process was occurring. This followed guidance from the British Society of Gastroenterology on decontamination of equipment for gastrointestinal endoscopy.

Staff cleaned equipment and the couch space after each patient to minimise the risks of cross infection. Staff labelled equipment with 'I am clean' stickers to show when it was last cleaned. This process gave assurance to staff that equipment were clean and ready for use. Visitors to the service were encouraged to clean their hands upon entry and exit. Hand sanitiser facilities were clearly signposted next to access doors and in the reception areas.

The service carried out regular audits of equipment, endoscopy decontamination and hand hygiene. Staff had achieved a compliance rate of 100% in the last audit which was completed in December 2019. There were clear systems that staff followed for the safe collection and transportation of specimens.

For our detailed findings on infection control, please see the Safe section in the Surgery report.

Environment and equipment

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

The endoscopy unit was located on the ground floor and consisted of a procedure room and two bedded recovery bays. The design of the environment followed national guidance and the premises were well maintained and clean. Consideration was given for people with limited mobility and wheelchair users with ramps and level access available to patients and visitors. There were adequate and suitable seating in the reception areas which included facilities for hot and cold drinks.

Endoscopy equipment was serviced at quarterly and yearly intervals under a service level agreement and records of checks and servicing were available and up to date. The staff carried out weekly checks of some equipment and water testing in line with guidelines. Resuscitation equipment was available on the trolley which was tamper evident and this had been checked daily in line with the provider's procedure.

The endoscopy procedure room was on the ground floor within proximity of the wards and theatres and staff had access to other emergency equipment if needed.

The service managed substances that were hazardous to health safely and in line with Control of Substances Hazardous to Health (COSHH) Regulation 2002, with doors to cleaning cupboards locked so cleaning products could not be accessed by unauthorised persons.

The service completed an audit of the environment and equipment training in February 2020 and achieved 95% compliance. An action plan was developed for spillage training as this was out of date. The staff were awaiting sign off for the new stack and endoscopy system. This equipment contains the light source and processor required for the endoscopes to produce images. Staff training was planned prior to the introduction of this monitoring system and the service had set a compliance date of May 2020.

Good

Medical care (including older people's care)

The service was in the process of developing a separate room in order to effectively support patients requiring bowel preparation prior to their procedures.

For our detailed findings on environment, please see the Safe section in the Surgery report.

Assessing and responding to patient risk

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

Patient risks were assessed prior to the procedure and included those patients who had diabetes or were on blood thinning medicines. Patients were given clear advice regarding pre- procedure fasting to ensure they did not go for longer period that was necessary without food and fluids.

Staff completed risk assessments for each patient. The service followed procedures to ensure patients had appropriate pre-procedures checks before attending for an endoscopy. The service delivered diagnostic endoscopy procedures and had clear exclusion criteria to ensure patients' safety and risks of avoidable harm.

Patients were monitored and baseline observations were undertaken during the procedures such as pulse, and blood pressure were recorded. Staff followed the World Health Organisation (WHO) guidelines (5 steps to safer surgery) to ensure patients received their procedure safely. The WHO checklist is a nationally recognised system of checks designed to prevent avoidable harm and mistakes during surgical procedures. The service had an adapted version of the WHO checklist for endoscopic procedures.

Staff used the national early warning system (NEWS 2) tool to identify deteriorating patients and escalated them appropriately. NEWS 2 is the National Early Warning Scoring system developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes.

The service had procedures in place to deal with unexpected bleeding and staff told us that the resident medical officer and other staff would attend from the other department including theatres to offer support in the safe management of patient's emergency. There was a service level agreement with the local NHS trust for the safe transfer of patients requiring emergency care.

Risk assessments were carried out for aspects of decontamination of re-useable medical devices; use of chemicals, spillage and audited to ensure compliance.

For our detailed findings on assessing and responding to risks, please see the Safe section in the Surgery report.

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 endoscopy service had a lead nurse, a registered nurse and a healthcare assistant for each procedure list. Competent staffing levels and skill mix adhered to the British Society of Gastroenterology (BSG) guidance. Staffing was reviewed daily during the safety huddles and managers had an oversight of staffing ensuring that the procedure list was adequately covered in order to provide safe care.

For our detailed findings on staffing, please see the Safe section in the surgery report

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.

Patients were admitted under a named consultant who retained the overall responsibility for the patients throughout their admission. Gastroenterologists were accepted to carry out procedures at the service as this was part of their regular NHS practices.

As part of the granting of practicing privileges agreement, all consultants were required to be available within 30 minutes to attend any patient who required a review.

For our detailed findings on medical staffing, please see the Safe section in the Surgery report

Good

Medical care (including older people's care)

Records

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

All records were stored safely and securely in the endoscopy unit. Staff had access to patients' records including results of tests in order to provide safe and effective care. Patients records were detailed and included operative diagnosis, their findings and any complications.

Patients records also included an endoscopy procedure care pathway, past medical history, risk assessment, consent form, checklist such as the WHO five steps to safer surgery, observations, medicines and discharge plan.

Following completion of any procedure, a report was sent to the referring GP and a copy was also given to the patient on discharge.

The service carried out an audit of patients records in December 2019. They looked at five records in endoscopy and the audit achieved 94% overall compliance to audit standards. The outcome of the audit was shared with staff. The staff had been advised that all patient's records must evidence that a copy of their consent to procedure had been given to the patient. This element was planned to be re-audited February 2020 to assess compliance.

For our detailed findings on records, please see the Safe section in the Surgery report.

Medicines

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

The staff followed procedures for the safe management of medicines. Medicines were managed safely and securely and in line with guidance. Emergency medicines were available in the endoscopy unit such as those needed to deal with anaphylactic shock (severe reactions to certain medicines) and for severe bleeding.

Patients allergy status was clearly recorded on their notes, care pathways and identity band, which alerted staff to the risk.

For our detailed findings on medicines please see the Safe section in the Surgery report.

Incidents

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

There had been no incidents that met the serious incident criteria reported for the endoscopy service. Staff understood duty of candour (DoC) a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff were aware of their responsibility to inform patients when anything went wrong. They said that the consultants would initiate this and the clinical lead for the service would be part of the investigations.

There were no never events reported during the reporting period 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.

For our detailed findings on incidents please see the Safe section in the Surgery report.

Are medical care (including older people's care) effective?

Good

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

Evidence-based care and treatment

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

Good

Medical care (including older people's care)

The hospital had procedures and policies to ensure that care and treatment was delivered in line with national guidelines such as the National Institute for Health and Care Excellence (NICE). Other guidance included the European society of gastrointestinal endoscopy for bowel preparation prior to colonoscopy.

Staff followed the Health Technical Memorandum 01-06 (HTM) for the decontamination of flexible endoscopes. Staff were aware that flexible endoscopes were fully compliant with the "Essential Requirements" of the Medical Devices Regulations 2002. This implies that the endoscope should be: clean and high level disinfected at the end of the decontamination process; and maintained in a clinically satisfactory condition up to the point of use.

The endoscopy decontamination area and processes were in line with the British Society of Gastroenterology (BSG) guidelines for decontamination of equipment for gastrointestinal (GI) endoscopy.

Staff followed the fasting guidelines in line with the Royal College of Anaesthetists and National Institute for Health and Care Excellence (NICE).

Managers ensured staff had access to the latest guidelines and standard operating procedures relating to endoscopy and audited this at regular intervals.

For our detailed findings on evidenced base practice, please see the Safe section in the Surgery report.

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.

Staff followed guidance to ensure that patients did not fast for longer periods than necessary prior to their procedures. Information about fasting was provided when patients attended for the pre -operative assessment. Staff contacted patients 48 hours before their admission and fasting information was shared.

The service followed the fasting guidance in line the national and European anaesthesia society recommendation. Patients were advised on intake of clear fluids up to two hours before the induction of anaesthetic as well as six hours fasting for solid food prior to procedures.

Patients were offered a variety of refreshments post-procedures based on risks. There was clear information that was shared with patients who had their throat sprayed, as part of the procedure to ensure it was safe for them to eat and drink.

For our detailed findings on nutrition and hydration, please see the effective section in the Surgery report.

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.

Patients were given information about pain management as part of their admission process. Staff monitored patients' pain during procedures and were supported to communicate pain and discomfort. Patients were administered an anaesthetic throat spray prior to their procedures such as gastroscopy to ensure patients comfort during the procedures.

Staff supported patients and continuously assessed their level of pain or discomfort during procedures that we observed. Patients were encouraged to report pain and discomfort including offer to pause during procedure. Patients told us they were satisfied with the information on pain and discomfort and that the procedures were not painful. Staff had access to pain assessment tool for patients who may not be able to verbalise their pain and staff said patients would be supported to use this as needed.

For our detailed findings on pain relief, please see the effective section in the Surgery report.

Patient outcomes

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

Good

Medical care (including older people's care)

The service submitted data to the National Endoscopy Data Base on gastrointestinal endoscopy as part of their (JAG) accreditation. The service had achieved the Joint Advisory Group (JAG) accreditation. This is an accreditation patient centred scheme and based on independent assessment against recognised standards.

The national endoscopy database provided benchmarked endoscopy performance reports, allowing endoscopist, providers and commissioners to identify and act on potential issue. The data submitted reported on patient's outcome such as successful intubation (insertion of flexible camera into the stomach). For patients undergoing colonoscopy it looked at bowel preparation processes (medicine taken to clean the bowel in order to thoroughly examine the bowel).

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. Staff training comprised of e-learning and face to face and staff were allocated time for training with a rolling training programme scheduling one day a month for clinical updates and a half day a month for non-clinical updates.

The service had a detailed induction programme that included infection control, decontamination of instruments, medicines management, sharps management. The provider's specialist pain nurse provided pain management training and competency for nursing staff.

Managers identified staff's training needs and gave them the time and opportunity to develop their skills and knowledge. The service supported staff to undertake training in order to maintain their professional registration and revalidation requirement. Revalidation is a process to ensure staff had undertaken training and development to maintain their skills to remain on the professional registers. The service also checked staff had current registration in order to allow them to practice. Managers made sure staff attended team meetings or had access to minutes when they could not attend.

For our detailed findings on competent staff, please see the effective section in the Surgery report.

Multidisciplinary working

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

We observed effective multidisciplinary working and staff told us they felt supported by the other team members at the service. Staff told us they worked closely with the theatre team and could give examples when the team had come from theatre to support staff and patients.

For our detailed findings on multidisciplinary working, please see the effective section in the Surgery report.

Seven-day services

The endoscopy service did not operate seven days a week.

The endoscopy service operated between 8am and 6pm, Monday to Friday for elective referrals. The provider told us the endoscopy service provided emergency care/treatment for patients admitted for procedures if required.

Patients followed an elective pathway for their procedures. This information was also available to patients when choosing services.

Patients were provided with a contact number following discharge to enable them to seek advice and support out of hours.

For our detailed findings on seven-day services, please see the effective section in the Surgery report.

Health promotion

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

The service had a variety of leaflets including healthy eating, weight reductions and smoking cessation in the waiting areas which were accessible to patients and visitors.

For our detailed findings on health promotion, please see the effective section in the Surgery report.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Good

Medical care (including older people's care)

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

Staff had completed training in consent and Mental Capacity Act 2005 and knew how to access support if they had any concerns regarding consent. They told us they would follow guidance to ensure decisions were made in patients' best interest and took into consideration patients' wishes.

The unit had a consent policy, which was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent, details on the Mental Capacity Act 2005 (MCA). Staff had access to the policy and had received training in completing stage two consent in line with the provider's guidance.

Staff clearly recorded consent in the patients' records. We reviewed consent forms for endoscopy which showed these were fully completed, signed and dated to ensure they were valid. The consultants gained consent from patients prior to the procedures which also highlighted any associated risks.

Staff made sure patients consented to treatment based on all the information available. At the pre- assessment stage, patients were given information about the procedure in order to assist them in making informed decisions about their care and treatment.

The endoscopy service carried out a consent audit and looked at five patients records in December 2019, which achieved 100% compliance. The audit looked at evidence that the intended benefits of the procedure had been discussed with the patient. The audit found consent forms were fully completed and signed included patient details on each page and the patient copy of the consent form.

For our detailed findings on consent and mental capacity, please see the effective section in the Surgery report.

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.

We observed compassionate and caring interactions from all staff. Patients were positive about the care and treatment they received.

Patients were treated as individuals and staff spoke to patients in a kind and sensitive manner.

Staff were friendly, polite respectful and courteous. Feedback received from people who used services and those close to them was consistently positive.

Patients were treated with respect and dignity and were made to feel comfortable during the procedure. Patients were offered chaperones to accompany them during their hospital's visit and this information was available to them. Staff were clear about their roles in acting as chaperones and the service had arrangements in place to ensure a staff member was available to support the patient as needed.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff supported patients who became distressed and helped them maintain their privacy and dignity. We observed staff giving explanation and reassurance to patients in the procedure room and checking that they were all right.

We received positive feedback from patients about the emotional support and reassurance they received to relieve their anxiety.

For our detailed findings on emotional support, please see the caring section in the Surgery report.

Understanding and involvement of patients and those close to them

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

Patients were positive about the information and support they had received prior to and during the procedure. Information leaflets were made available and patients had

the opportunity to ask questions at various stages during their appointment. Patients were given appropriate and timely information to assist them in making decisions and alleviate their anxiety. Staff recognised the impact of care and treatment provided on the patient and those close to them.

For our detailed findings on understanding and involvement of patients and those close to them, please see the caring section in the Surgery report.

Are medical care (including older people's care) responsive?

Good

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

Service delivery to meet the needs of local people

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

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The service was well organised and had separate male and female lists to effectively meet the needs of people. During the inspection arrangement was made for a male patient who had to stay longer and was accommodated on the first floor. This ensured there was no cross over of male and female patients and the afternoon list went ahead as planned.

Facilities and premises were appropriate for the services being delivered. The provider had reviewed the current facility for patient requiring bowel preparation prior to their procedure. They were planning to convert a room where patients would have direct access to toilet facility when undergoing this procedure and this would impact positively on patients.

The service admitted some patients under a contract from the local Clinical Commissioning Group helping to reduce the demand on the local NHS. There were agreed referral criteria for patients attending for procedures and treatment at the hospital.

All patients' admissions for endoscopic procedures were on a planned basis, patients were referred and followed an elective pathway for diagnostic procedures.

For our detailed findings on service delivery to meet the needs of local people, please see the responsive section in the Surgery report.

Meeting people's individual needs

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

The service took account of patients' individual needs. Patients were referred by their GP using an electronic referral system. Patients used the choose and book system, they received a referral confirmation letter containing their unique booking reference number and password. Once this letter was received, patients booked an appointment to suit their needs and preferences within an agreed priority framework depending on the severity of their symptoms.

Patients received written information ahead of their appointment which included specific instructions and information about what to expect as part of their care and treatment.

For our detailed findings on meeting people's individual needs, please see the responsive section in the Surgery report.

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.

Between October 2018 and September 2019, the service had undertaken 344 procedures for endoscopy services. These included upper and lower diagnostic endoscopic procedures, colonoscopy, flexible sigmoidoscopy and diagnostic colonoscopy.

The service was 100% compliant with the referral to treatment performance standard of 18 weeks. All patients undergoing endoscopy and sigmoidoscopy procedures were seen within two weeks of referral.

Good

Medical care (including older people's care)

The service held regular meetings with the clinical commissioning group (CCG) and provided update on their performance, as part of the contract.

Managers told us they did not currently provide bowel screening, and this was an area that the service was exploring and discussing with consultants in order to develop this service.

For our detailed findings on access and flow, please see the responsive section in the Surgery report.

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.

There were clear procedures to support patients and their relatives in raising a complaint or concerns about the service. Information leaflets included tell us about your care and raising concerns were available. Staff told us they received very few concerns and they were pro- active in resolving them at the time if possible.

For our detailed findings learning from complaints and concerns, please see the responsive section in the surgery report.

Are medical care (including older people's care) well-led?

Good

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

Leadership

Leaders had the skills and abilities to run the service; the Hospital Director provided leadership to a competent senior leadership team. The team, supported by corporate senior staff, understood and managed the priorities and issues the service faced

The hospital had a hospital director who was also the registered manager and was in charge of the day to day management of the service. They were well informed about the service, the staff team and the challenges the organisation faced.

The senior leadership which included the theatre manager met weekly and had a rotating focus for their meetings. There was a four-weekly cycle of focus that revolved through finances, business development, quality and facilities joined with personnel.

The theatre manager had overall responsibility for the endoscopy unit and staff told us they had excellent working relationship between the teams and received good support.

For our detailed findings on leadership, please see the well led section in the Surgery report.

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

Service had a vision for the development of the endoscopy service and increasing activity. Staff we spoke with were focussed about the vision for the service and how to achieve this. They told us they were exploring with consultants and commissioners about providing bowel cancer screening service which was not currently available at the hospital.

For our detailed findings on vision and strategy, please see the well led section in the surgery report.

Culture

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

Staff we spoke with described their culture as being supportive and respectful to colleagues. Staff said they felt there was a positive culture with good team work and supportive senior managers.

Staff told us they were proud to work for the service. All staff nominated for an 'Above and Beyond' award received a letter detailing why they had received the award. and a

free lunch voucher. A staff member in endoscopy was nominated for the assistance and extra hours they had worked to support the service due to an unplanned staff's absence.

For our detailed findings on culture, please see the well led section in the Surgery report.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had opportunities to join meetings.

The governance structure was well developed and linked into the head of department meetings, governance meetings, medical advisory committee, endoscopy user group meetings. The national lead for endoscopy sat on de-contamination working group, and infection prevention committee.

The endoscopy service was reassessed for the JAG accreditation in September 2019. An action plan was developed, and evidence submitted, and the service was successfully awarded JAG accreditation.

The endoscopy service had an annual audit plan with named leads and timescales for completion.

For our detailed findings on governance, please see the well led section in the Surgery report.

Managing risks, issues and performance

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

The service had a clear risk management policy and process for the identification, assessment and control of risks for endoscopy services. The policy set out how risks should be calculated depending on the impact and likelihood of a risk.

For our detailed findings on managing risks, issues and performance, please see the well led section in the Surgery report.

Managing information

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

Staff could refer to relevant patients' records in order to provide care and treatment appropriate to their needs.

Computers were password protected and locked when not in use. Staff were aware of the data protection regulations relating to patient records and their secure management.

For our detailed findings on managing information, please see the well led section in the Surgery report.

Engagement

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

The staff survey identified two key areas for their action plan, as communication and reward and recognition. Managers were setting up lunches and afternoon teas as some informal measures to improve communication. There were also monthly newsletters and staff forum to maintain staff engagement.

As part of improving communication with patients who were enquiring about paying for their care, there was a process for all enquiries to be directed to the private patient manager. This was to ensure patients were sent information and followed up to check they had the information they required.

For our detailed findings on engagement, please see the well led section in the Surgery report.

Learning, continuous improvement and innovation

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

The hospital was the only provider in the Reading area that was JAG accredited. The current Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation scheme

was established in 2005 and, along with the Global Rating Scale (GRS), has supported endoscopy services across the UK to focus on standards and identify areas for development. There are currently only 67 independent hospitals in England that have achieved accreditation.

Good

Surgery

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

Are surgery services 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 service had a mandatory training schedule which all staff completed in order to be able to undertake their roles. The registered manager was responsible for monitoring compliance and reminded staff when they were due a refresher course. Mandatory training data showed staff were 93% compliant with training requirements as set by the hospital.

Staff had completed training in modules including but not limited to, intermediate and advanced life support, consent, health and safety, infection control and moving and handling, fire safety and record keeping.

Medical staff received and kept up-to-date with their mandatory training. The service had doctors and anaesthetists who worked under practising privileges. They were required to provide evidence from their current NHS role of their compliance with mandatory training as part of their practicing privileges. This information was checked and recorded in the individual staff's file and we found this was up to date.

Safeguarding

Staff and leaders 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 service had effective systems to support the staff in raising safeguarding concerns. Safeguarding referral forms were available and staff knew how to access and use them.

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

Staff knew how to identify adults at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff told us of an example where they had raised concerns with the patient's GP.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The head of clinical services (matron) was the lead for safeguarding and had oversight of any referrals made in order to support staff and patients. The provider had corporate safeguarding adults and children policies that reflected the current national guidance.

Safeguarding training compliance was considered at the monthly senior leadership team meeting. The completion rates were good. Staff who did not complete the safeguarding training were asked to do so. If they had not completed it within the timeframe set,. they were removed from their usual duties and given time to complete the training. New staff were not allowed to begin their usual duties until they had completed the required level of safeguarding training.

Data showed that 99% of the staff across the hospital had completed their children and adult safeguarding training at the levels one and two. For child safeguarding the completion was 100%, excluding staff on leave or long-term sickness absence.

The head of clinical services (matron) was the named nurse for safeguarding. She attended the West Berkshire Named and Designated Professionals twice yearly meetings. The hospital director held a current level 5 qualification in safeguarding and supported staff with safeguarding concerns at the service. Each department had a safeguarding champion and staff were aware who they were and how to contact them.

Safeguarding was discussed at head of department meetings as well as at the senior leadership meeting to ensure that there was learning from any incident and that there was dissemination of information.

The head of clinical services (matron) had a date to attend a train the trainer course for safeguarding supervision. This would allow additional staff to be trained to offer safeguarding supervision in house.

We were given an example of a recent potential safeguarding concern that was raised by a member of the nursing staff. The patients GP had been contacted and followed up the concern, to ensure all was well and that a safeguarding referral was unnecessary. The GP visited the patient and fed back to the hospital that there was nothing of concern and there was a reasonable explanation for some bruising.

The hospital did not treat any children and patients were actively discouraged from attending for appointments with children. Staff had completed the necessary level of child safeguarding training but had not had to make any referrals.

The service had a rolling training programme for PREVENT/ WRAP and 81% of staff had completed this training as of April 2019. PREVENT raises awareness to stop individuals from getting involved or supporting terrorism or extremist activity. PREVENT is the duty in the Counter-Terrorism and Security Act 2015 by which staff in health care settings must have training to identify ways to prevent people from being drawn into terrorism or extremist activity.

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.

The ward, operating theatres and other areas we reviewed were clean and bedrooms and reception areas had suitable furnishings which were clean and well-maintained.

Staff followed their infection control procedures as patients were all accommodated in single rooms and patients who were suspected of having an infectious condition were isolated. Staff kept visitors and relatives informed on procedures they needed to follow such as use of personal protective equipment and hand washing to minimise the spread of cross infection.

Between January and December 2019, the service had no cases of healthcare acquired infection Methicillin-resistant Staphylococcus aureus (MRSA). Procedures had been developed to assess patients and they were routinely screened for MRSA as part of their pre- operative process. Staff followed their procedures, including routine testing of susceptible patients in line with best practice guidelines.

The service generally performed well for cleanliness. The service took part in patient-led assessment of care environment (PLACE) assessments. These were annual appraisals and assessment of the environment and supported the provision of care. Areas looked at include cleanliness, food and hydration, privacy, dignity and wellbeing, condition appearance and maintenance, dementia, and disability. Results from this assessment were published by the NHS health and social care information centre and on the service's website. The service achieved consistently high PLACE scores, and this was between 95-100% in 2019.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed guidelines such as bare below the elbow procedures were followed in clinical areas. Staff adhered the five moments of hand washing in line with the world health organisation (WHO) protocols to prevent the spread of infection. The service carried out monthly hand washing audits and

cleaning audits to monitor adherence to infection control practices. The latest audit results ranged between 98% and 100%. The results were shared with the staff and an action plan to achieve compliance was developed as needed.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. The use of 'I am clean' stickers were consistently used to identify clean equipment. This process gave assurance to staff that equipment were clean and ready for use. Visitors were encouraged to clean their hands upon entry and exit to the service. Hand sanitisers were available and clearly signposted next to access doors. In addition, clinical staff undertook further training and assessment of competencies in aseptic no touch techniques to effectively manage infection control risks.

Staff used records and data to identify how well the service prevented infections. They monitored their surgical site infection rates for procedures which included hip and knee arthroplasty, orthopaedic and trauma surgical site infections, breast surgery and urology. Between January and September 2019, the service had declared they had one surgical site infection.

The hospital had a service level agreement with microbiologists at the local NHS trust to provide expert advice and guidance. The service liaised with the microbiologist and sought advice on treatment for infection and antibiotics therapy as needed.

The two operating theatres had a laminar flow (a system of circulating filtered air to reduce the risk of airborne contamination). This worked to prevent airborne bacteria from getting into open wounds, as well as removing and reducing levels of bacteria on exposed surgical instruments.

Staff followed good practice guidance and procedures for maintaining clean and dirty flow within operating theatres. This included limiting the number of staff entering the operating theatre during surgery and restricting the movement of personnel in the operating theatre to a minimum. There was an effective facility for the sterilisation of surgical instruments. Theatre staff told us there were no problems obtaining instruments in a timely way with a turnaround time of 48 hours for routine equipment.

There were some clinical areas at the service that were carpeted which did not comply with infection control policy and practice guidelines. Carpeted areas posed infection control risks as spillages including body fluids may not be adequately cleaned. This had been identified and discussed at provider's level and was on the service risk register. Managers told us this was on the provider's programme as a priority for refurbishment.

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 and the premises were well maintained and clean. Consideration was given for people with limited mobility and wheelchair users with ramps and level access was available to patients. There were adequate and suitable seating in the reception area and included facilities for hot and cold drinks. The ward consisted of single rooms with en- suite facilities. All the bedrooms were for single occupancy with en-suite facilities with easy access to people with limited mobility. There were also four double rooms which staff said could be used for wheelchair users as these rooms were bigger. These rooms were also at times used to support patients and their carers.

Staff carried out daily safety checks of specialist equipment including the emergency resuscitation trolleys and equipment used in the operating theatres. The service had enough suitable equipment to help them to safely care for patients. The staff had received training in the use of equipment which depended on the area that they worked.

The resuscitation trolleys contained tamper evident tags, and these were checked daily and records of checks were available. Emergency equipment stored in the resuscitation trolley showed single-use items were sealed and in date.

In theatres staff carried out daily checks of anaesthetic equipment prior to the start of the surgery list in line with the Association of Anaesthetists of Great Britain and Ireland guidelines. They followed the anaesthetic equipment checklist and recorded this once completed. This also provided assurance that equipment was ready for use and used as an audit trail to monitor compliance.

There was a dedicated physiotherapy suite with five treatment rooms and one gymnasium; all departments were well maintained, fully equipped and accessible to patients.

The service had a process to test electrical equipment providing assurance that they were safe for use. This is known as portable appliance testing (PAT). We carried out a check of approximately 16 equipment on the wards and the operating theatres. All had a label indicating the device had been PAT tested and included a due date for retest. In theatres, the laminar flow system was tested by the contracting company. All items checked had passed an electrical safety test within the last 12 months.

Staff managed substances that were hazardous to health and safely and in line with Control of Substances Hazardous to Health Regulation 2002 (COSHH). These substances were stored securely, and cupboards were locked so cleaning products could not be accessed by unauthorised persons. Staff were aware of the procedures and who to contact in the event accidental exposures to cleaning products.

The hospital managed clinical waste well and followed guidelines in line with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. They disposed clinical waste safely and these were removed from the dirty clinical rooms at regular intervals to reduce infection control risks. Sharps boxes were available and marked with ward's name and date they were assembled. These were not overfilled, and the lid closed when not in use to prevent risk of accidental exposures or injuries.

The storage area of external clinical waste bin was not secure during the inspection. This posed risk of unauthorised persons having access to clinical waste. We raised this with the registered manager and actions were taken to reduce the risks.

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 the national early warning system NEWS2 tool to identify deteriorating patients and escalated them appropriately. NEWS2 is the National Early Warning Scoring system developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. All staff had received an update and training on the use of the NEWS2 tool.

Staff completed risks assessments for patients on admission using recognised tools. These assessments included risks of malnutrition; staff used the malnutrition universal screening tool (MUST) for this assessment. Patients were also assessed for risks of fall using the fall risk assessment tool and pressure damage to skins using pressure damage risk score tool. Care plans were developed using this information to provide care and treatment and minimise risks and the plans were reviewed following any changes. Patients at risks of falls were referred to the physiotherapy team for advice and support. This information was included in the care plans for staff to follow.

Patients undergoing elective surgery had a pre- assessment as part of their process. This was a means to identify patients' suitability and other pre-conditions that may lead to patients' complications during the anaesthetic, surgery, or post-operative period. The service was working with a local provider to implement a weekly anaesthetist led pre-operative assessment clinic. Staff raised any patient's health concerns with the consultants during the pre-assessment stage in order to ensure a review was completed. They said they could access the consultants in a timely way as they ran outpatient clinics at the same time.

Patients were assessed for the risks of venous thromboembolism (VTE, or blood clots). The service acted to reduce identified risks. Patients records showed they had been prescribed anti-coagulants (medicines to prevent blood clots) and compression stockings and boots were used, as clinically indicated to reduce the risk of blood clots during and post-surgery. Some patients were also discharged home with anti- coagulants medicines according to their risks.

VTE audit was undertaken in February 2020 and the service had achieved 89% compliance with their patients' assessment. The service had identified that consultants were not signing the VTE forms in line with their internal process. An action plan had been developed to achieve compliance and this would also be discussed at the next head of department meeting.

The service had procedures to recognise and respond to sepsis (severe blood infection) in line with national guidance. Sepsis is a rare but serious complication of an infection that can lead to multiple organ failure and death if not treated promptly. The service had developed a sepsis

screening and action tool, which staff used for the recognition of sepsis. There was a sepsis box which had been developed as part of learning from incidents. This contained all the necessary information and equipment to identify and the appropriate management of patients with sepsis.

Staff followed the World Health Organisation (WHO) guidelines (5 steps to safer surgery) to ensure to ensure patients received their operation safely. The WHO checklist is a nationally recognised system of checks designed to prevent avoidable harm and mistakes during surgical procedures. These checks consisted of team briefing, sign in (before anaesthesia), time out (before surgery starts), sign out (at the end of the procedure) and debrief. We observed all five steps of the WHO checklist, and saw staff fully completed and engaged in all the required checks.

Patients' blood results were checked prior to surgery to ensure the procedure could be carried out safely. The service had blood products such as (O) negative blood on site for emergency and had a service level agreement with the local NHS trust and could access blood products in an emergency.

During the handover in the anaesthetic room for example, patients checks included surgical site marking and any known allergies in line with the five steps to safer surgery. Our observation in the operating theatres showed staff were engaged during the WHO checklist process and adhered to guidance. We reviewed six patients' records which showed the WHO checklists were fully completed. The anaesthetist stayed until the patient was out of recovery and satisfied that the patient was safe to be transferred to the ward.

Staff shared key information to keep patients safe when handing over their care to others, this included verbal feedback and they completed detailed transfer forms when handing over patients care to external providers. Shift changes and handovers included all necessary key information to keep patients safe. There was a daily safety huddle each morning. This included allocation of the specific roles for the emergency response team. Identification of named staff to complete the specific tasks associated with a resuscitation attempt is important to avoid confusion and chaos in the event of an emergency. There was a service level agreement with the local NHS trust for transfer of patients requiring emergency care.

The role of each person was clear, and all roles had an allocated staff member and sharing of any individual patient's concerns where they had a NEWS2 Score of over 2. A virtual huddle took place each evening with the nurse in charge and resident medical officer always present. On the day of the inspection the huddle board showed that a patient who had a NEWS2 score of 3 was discussed. There was appropriate escalation of the concerns at the time and with the correct management, the patient's condition improved, and the score returned to within normal parameters. This meant that senior staff had oversight of any patients who were at risk of an unexpected deterioration and could intervene at an early stage to ensure that the patient received appropriate care and treatment to manage their condition.

In the operating theatres, the service had introduced a lead safety officer (LSO), where a staff member was allocated for each operating list. They wore a red hat which made them easily identifiable and the LSO was responsible to ensure safety procedures were adhered to. Procedures were used for tracking and traceability of instruments and prosthesis for patient's safety.

The service had a close observation room where patients received 1:1 care and non-invasive monitoring. Patients were transferred to a more appropriate hospital in a timely way, when their condition warranted it. One patient had an unrelated complication after an anaesthetic for a minor surgical procedure. As soon as the excessively fast pulse was identified, the patient was returned to the recovery area under the care of an anaesthetist and transferred to a local NHS coronary care unit where they received treatment for the condition. The service carried out a full investigation and it became apparent the patient had been treated for this condition previously but had not informed the staff at the pre-admission assessment nor on admission. The patient was followed up by hospital staff and had made a full recovery. The GP was informed of the incident so the patient could continue to receive treatment.

Nursing and support 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 used their electronic rostering system and managers undertook a daily review of staffing to ensure patients continued to receive safe and consistent care. Theatres followed the Association for Perioperative Practice (AFPP) guidelines. The Association for Perioperative Practice (AFPP) recommended minimum theatre staffing levels of two scrub practitioners, one circulating staff member, one registered anaesthetic assistant practitioner and one recovery practitioner for each theatre list. We observed that theatre staffing met these recommendations and a senior staff told us they would not run a list without adequately skilled staff. The staff told us they worked as a team and used their bank staff and block booked agency staff to promote consistency in care.

Staff were positive about the staffing and told us they always had adequate staff to meet patients' needs. We reviewed the allocation of staff and duty roster which showed the service met their planned schedule for a trained nurse to five patients during the day and one trained nurse to seven patients at night. The duty roster showed the staffing level was above the recommendations for qualified nurse to patient ratio. The service used their own staff to cover any shortfall in staffing and bank and agency staff had a full induction programme which was followed. Staffing was reviewed daily for the forthcoming shifts and adjusted according to clinical need and theatre activity. The daily safety huddle was followed by the 10@10 briefing where planned activity was reviewed to ensure optimal staffing levels were maintained and agency use was kept to a minimum by planning and using their own 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.

Patients were admitted and treated under the direct care of a consultant and medical care was supported 24 hours a day seven days a week by an onsite resident medical officer (RMO). The RMOs were contracted from an agency and they worked on a rotational basis. The agency arranged for the RMO to have up to date mandatory training, including advanced life support training. The agency provided the service with evidence of completed training modules. Resident medical officers provided daily medical services and dealt with routine and emergency situations. as needed.

The consultants who admitted patients retained the overall responsibility for the patients throughout their admission. As part of the practicing privileges agreement, all consultants were required to be available within 30 minutes to attend any patient who required a review. All new consultants received a full induction to the service when they started. Consultants working under practicing privileges only carried out procedures and surgery in line with their scope of practice and substantive role within their NHS work.

Staff told us the consultants were supportive and could be contacted by phone for advice and attended the service as required. The consultants undertook a daily review of the patient under their care and plan of care was developed and communicated to the clinical staff and recorded in the patient's notes.

An integral part of the safety huddle was checking that the RMO had had enough sleep and breaks to allow them to continue to practice safely. A senior manager told us if the RMO had a disturbed night and were too tired to work through the day, the agency was asked to supply an additional RMO for the day. The service had contracted with an external provider to provide anaesthetic cover and support for the emergency transfer of patients.

Records

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

The service used a paper record system and was planning to introduce an electronic record system later this year. During the inspection we reviewed 12 sets of patient records. We found records contained good details of patients' assessments and care plans were developed to support staff in meeting patients' identified needs.

Patient records were maintained securely in the nursing office which was accessed via keycode. The room was kept locked to prevent unauthorised access to confidential patients' records.

The theatre records were also comprehensive, contemporaneous and contained details of procedures. The care records contained pre-operative assessments, records from the surgical procedure, recovery observations, nursing notes and discharge checklists and assessments which were appropriate to the patient's clinical pathway.

All records were stored securely. We observed that access to the electronic patients' notes was password protected and staff ensured they logged off when the computers were not in use. We saw surgeon notes were detailed with evidence of daily reviews and clear post- operative management plans. Tests and investigations reports were available electronically which staff had access to. Staff had completed training in record management and data showed 100% compliance with this training.

When patients transferred to a new team, there were no delays in staff accessing their records. Patients who were transferred out had copies of their records sent with them as needed to provide up to date information and maintain continuity in patient's care.

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. The pharmacy team supported the delivery of effective medicines management. They undertook reviews of patient's medication on admission and ensured discharge medicines were prepared and ready as needed.

Staff followed current national practice to check patients had the correct medicines. Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. The resident medical officer (RMO) sought advice from the consultant surgeon or anaesthetist prior to changing any patient's medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. A senior staff member told us this would also be discussed at their daily safety huddles.

The consultant surgeon maintained overall responsibility for patients under their care and any changes in patients' medicines were approved by them or the anaesthetist.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. There was a standard operating procedure for access to the pharmacy out of hours and at weekends which staff followed. Any medicines removed were recorded in the pharmacy register and signed out. Medicines were stored in a locked room, with restricted access to authorised staff.

The pharmacy carried out medicines' reconciliation within 24 hours of the patient's admission to the service. This was to provide assurance that patients continue to receive their medicines safely. The pharmacist carried out an audit of medicines reconciliation and there was evidence that any discrepancies were addressed promptly with staff. Medicines rooms and refrigerators were monitored, and daily minimum and maximum temperature checks were completed. Any concerns were raised with the pharmacy team and staff told us the team was supportive.

Controlled drugs (CDs) were stored securely in line with the Misuse of Drugs (Safe Custody) Regulations (1973) and managed in line with the hospital-controlled drug policy. A review of the controlled drug register on the ward showed staff adhered to the medicines management policy and the register was fully completed which included two staff's signatures for the administration of CDs. The CD register was stored securely to minimise the risks of access by unauthorised persons. The head of clinical services (matron) was the nominated controlled drug accountable officer (CDAO) who had overall responsibility for the safe management of controlled medicines. The service undertook a CD audit in December 2019, and they achieved 99% compliance. An action plan was put in place and this was also discussed at head of department meeting.

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.

Good

Surgery

The service had systems and processes to report and record incidents. All staff we spoke with knew what incidents to report and used their internal on-line reporting system. Staff raised concerns and reported incidents and near misses in line with their local policy. Staff discussed incidents at handovers and at daily safety huddles. Incidents were discussed at the monthly meetings, which had a standard agenda, to discuss any incidents, which may have resulted in harm to patients.

From October 2018 and September 2019, the service had one incident that met the serious incident criteria. This related to a known risk for a gynaecological procedure. The service initiated their duty of candour process immediately following the procedure, the surgeon saw the patient to offer and apology and full explanation. This was followed with a letter in a timely manner and the patient was supported.

A senior manager undertook a root cause analysis (RCA) following any incident and action plan was developed to minimise the risk of re- occurrence. Investigation outcomes were shared with staff as part of lessons learnt.

The staff we spoke with were aware of their responsibilities relating to Duty of Candour (DoC) under the Health and Social Care Act (Regulated Activities Regulations) 2014. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify women (or other relevant persons) of "certain notifiable safety incidents" and provide them with reasonable support.

The provider had a corporate incident reporting policy that adhered to the NHS standard contract arrangements and the legislative requirement to notify the Care Quality Commission in specific circumstances.

Incident governance processes were effective and gave the hospital leaders and the provider appropriate oversight of incidents and how they were managed. The senior leaders at the hospital understood the reporting requirements and formally reviewed incidents for actions and trends, through the monthly senior leadership meetings. Staff were encouraged to report incidents and to use them as a tool to drive improvements. Actions were taken to mitigate the risk of recurrence.

There were 19 incidents reported. Most of these were near misses and cancellations on the day of surgery for clinical reasons such as a patient turning up for surgery with a heavy cold or who had made false declaration about their weight and smoking status during a telephone pre-operative assessment.

The threshold for responding in writing to apologise, when something went wrong was set a lower level than the guidance about the duty of candour required. There was an open culture and a commitment to transparency that meant the senior staff responded quickly and with honesty to patients.

One example was a patient who had suffered a known complication during surgery that resulted in the need to wear a sling for a little longer than was originally planned. They received both a verbal explanation and a duty of candour letter. A statutory notification was also submitted in the correct way to the Care Quality Commission.

Never events

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.

From December 2018 to November 2019, the service has declared there was no never event.

Safety Thermometer (or equivalent)

The service monitored patient's safety risks such as falls, pressure ulcer and venous thrombosis (Blood clots in veins). They had a good track record on providing harm free care. In the reporting period December 2018 and December 2019, the service had reported one hospital acquired deep vein thrombosis. They had no incidents of falls with harm and hospital acquired pressure ulcer.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care.

Good

Surgery

Are surgery services effective?

Good

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

Evidence-based care and treatment

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

The service had procedures and policy to ensure that care and treatment was delivered in line with national guidelines such as the National Institute for Health and Care Excellence (NICE) and the Royal college of Surgeons (RCOG) guidance. Examples of guidelines used included management and decontamination of surgical instruments (medical devices) used in acute care HTM 01-01:

Patients assessed to be at risk of venous thrombo-embolism VTE (blood clots) were offered VTE prophylaxis in accordance with NICE QS3 guidance. The surgery team provided predominantly elective surgery and patients had routine pre-operative tests in line with NICE guideline NG45.

In the operating theatres, staff monitored patients' temperatures in line with NICE Clinical Guideline CG65-Hypothermia: prevention and management in adults having surgery.

Staff monitored patients closely following surgery in line with NICE guideline CG50: Acutely ill patients in hospital-recognising and responding to deterioration. We reviewed seven patients' records, which showed evidence of regular observations such as blood pressure, heart rate, pulse and oxygen saturation, in line with the guidance.

Staff followed guidance for surgical site infection-prevention and treatment in line with NICE guideline (NG125) which included antiseptic skin preparations and antibiotics before skin closures.

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.

The service audited staff compliance with their policies and national guidance. This included regular audits on the World Health Organisation (WHO) Surgical Safety Checklist. Audits provided assurances around adherence to the safety checklist and helped identify areas for improvement.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Patients were encouraged and supported to mobilise following orthopaedic procedures to enhance their mobility and reduce the incidents of blood clots.

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 adjusted for patients' religious, cultural and other needs.

Patients were assessed for the risk of malnutrition using a nationally recognised screening tool and records were maintained. Care plans were developed and information about patients' nutritional needs were shared among the team.

Patients spoke positively about the food choices and the variety of meals they received during their stay. They told us the' food was really great' and they had numerous choices on the menu they could choose from. We were told the meals were always presented nicely and were appetising. Staff told us patients could opt for something off the menu and this would be provided. Staff considered patients' diverse dietary and cultural needs such as vegetarian religious and diabetics and arrangements were in place in meeting these needs. Hot and cold drinks and snacks were always available. Staff told us the service could access food to meet the religious needs of patients, as the chef would be able to source this locally as needed.

Information about fasting was provided when patients attended for the pre -operative assessment and prior to surgery. Staff contacted patients 48 hours before their admission and fasting information was shared. The service followed the fasting guidance in line the national and

European Anesthesia Society recommendation. Patients were advised on intake of clear fluids up to two hours before the induction of anaesthetic as well as six hours fasting for solid food prior to surgery. This ensured patients did not go without food and fluids for longer periods than necessary.

Food and fluids records were fully completed to ensure patients continue to receive consistent care and meet their dietary needs. Patients were prescribed and received intravenous fluids (through the vein) to maintain adequate fluid balance and reducing the risk of dehydration post surgery.

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.

Patients had access to a variety of pain relief as appropriate to their surgery. This included epidural, by injection or oral tablets and patient-controlled analgesia (PCA). Staff completed regular assessments when PCA was used to ensure that patients' pain was controlled, the equipment worked appropriately and monitored any unwanted side effects.

Patients' records showed staff took appropriate actions when patients pain was not well controlled. For example, the resident medical officer (RMO) would be contacted to review patients' pain prescription and liaised with the anaesthetist as necessary.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients records showed a pain assessment tool was used for patients who may not be able to verbalise their pain. Medicines records showed patients received regular pain control as prescribed and staff checked the effectiveness of pain relief. Patients received pain relief soon after requesting it. Patients told us their pain was well managed post surgery. A patient commented that the staff always checked if they were in pain and that their pain had been well managed. Patients were prescribed anti sickness medication to manage the side effect of some pain-relieving medicines.

The service had developed a booklet for patients with detailed information about managing their pain after surgery. This included a pain scale of one to 10, and the type of pain tablet to take for mild, moderate and severe pain. The service carried out a pain audit and looked at 10 patients records and their pain management in recovery and on the ward. The service achieved 95% compliance and showed patients received effective management of their pain. The non-compliance related to two records. In one record scores were not recorded on the observation chart or the anaesthetic record in recovery and in another there was a lack of evidence that pain assessment tool was used. Actions had been taken and staff reminded to complete records accurately.

Patient outcomes

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

The service participated in relevant national clinical audits. Patients were offered the opportunity to participate in the Patient Reported Outcome Measures (PROMS) and the National Joint Registry (NJR), for breast and other implants. registry. They also reported to the Surgical Site Infections (SSIs) data collection.

National Joint Registry recorded outcomes at this hospital for patients that underwent hip, knee and shoulder surgery. Hospitals were required to submit 100% of their eligible information to the National Joint Registry. In the reporting period for 2018 to 2019, the service had achieved 99% for PROMS and 100% for NJR submission. The service carried out an audit of 10 patients records in December 2019 and achieved 100% compliance for consent to care.

The results showed that the hospital was performing better than expected for the time taken to enter data into the NJR and their outcomes for knee surgery was similar/ as expected compared with other independent services. Patients were encouraged to participate in these audits if they had received treatment for hip and knee replacement, inguinal hernia repair and varicose veins. The service compared their local results with the provider's dataset and nationally with the NHS.

The service had good links with the local NHS service and followed up on the progress of any transfers out and reviewed the care pathway of any patients who may be readmitted within 28 days of having their procedure.

Between October 2018 to September 2019, the service had 12 unplanned readmissions and three transfers out to the local NHS trust. A senior staff told us this was monitored, and results were shared with the staff. Managers and staff used the results to improve patients' outcomes. This was discussed at the medical advisory committee (MAC) meeting and any lessons learned were shared with staff locally and at provider level.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The ward had a rolling audit programme included NEWS2, consent, patients' records, diabetes care. The world health organisation (WHO) checklist audit was undertaken by staff showed they achieved 99% compliance.

The theatre staff also carried out regular audit of the National Safety Standards for Invasive Procedures (NatSSIPs). This is a national safety standard aiming to reduce the number of safety incidents for invasive procedures in which surgical Never Events could occur. The latest audit was undertaken in January 2020 and looked at 10 patients' records. The service had achieved 99% compliance in their NatSSIPS audit. Action was taken and the outcome discussed with the staff at morning huddles to ensure all records were fully completed.

Managers used information from the audits to improve care and treatment. For example, the service audited 30 patients' medical records in September 2019 and achieved a compliance rate of 91%. This had identified doctors were not always recording that patients were fit for discharge although they had reviewed the patients. This had been raised with the doctors and a re-audit was planned in March 2020. Managers shared and made sure staff understood information from the audits and this was discussed at team meetings and at handover.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role including the resident medical officer (RMO) before they started work. Staff training comprised of e-learning and face to face and staff were allocated time for training with a rolling training programme scheduling one day a month for clinical updates and a half day a month for non-clinical update.

The service had a detailed induction programme that included medicines management, intravenous therapy, infection control, patients records and sharps management. The provider's specialist pain nurse provided pain management training and competency for nursing staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff in the operating theatre had specific induction modules including aseptic technique training. The RMO and senior operating department practitioners received advanced life support level training. Nursing and health care assistants completed intermediate life support training.

The service supported staff to undertake training in order to maintain their professional registration and revalidation. Revalidation is a process to ensure staff had undertaken training and development to maintain their skills to remain on the professional registers. The service also checked staff had current registration in order to allow them to practice. Managers made sure staff attended team meetings or had access to full notes when they could not attend. The manager told us the service had a rolling supervision programme to support the staff and identify areas of further development.

The provider had a nursing associate apprentice programme which was a two-year course. There was a staff member who was due to start this course in March 2020. Staff told us the provider was pro- active in developing staff and had supported the staff member to complete a foundation course to enable them to undertake this course. There was also an 18 months course for the development of aspiring leaders.

In the operating theatre there was one surgical first assistant per list. The provider has supported the

development of these staff to provide extra support to the theatre team and were separate to the scrub team. The training consisted of six study days and competency-based assessment prior to them undertaking this role.

The hospital monitored doctors' fitness to practice and required consultants to provide documented evidence of appraisal and revalidation in order to maintain practicing privileges. Data provided by the hospital showed that two consultants had practicing privileges suspended between July 2015 and June 2016 because this evidence was not submitted. In the same period, two consultants had practicing privileges removed because there were concerns with the standards of their practice.

Multidisciplinary working

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

During the inspection we observed effective multidisciplinary team (MDT) working throughout the service. MDT working was an embedded practice which supported the delivery of joined up care. Staff told us that communication was good from different disciplines such as physiotherapy, radiology, theatres and pharmacy team which they said provided positive outcomes for patients.

All care pathways were multi-disciplinary, and staff of all disciplines developed and supported each other in the planning and delivering of patient care. Each professional group recorded their assessments in the patient records which meant it was easy to access information about the outcome of the evaluation and the ongoing care of the patients. We observed handover between the surgeon and recovery nurse, the post-operative care was re iterated and documentation checked to ensure effective and safe patients' care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The multi-disciplinary team for example attended the daily safety huddles. The service had an in-house physiotherapy service which provided linked up care for patients. The physiotherapy team carried out full assessments of patients and developed plans of care. Assessments and plans were shared with the multi-disciplinary team and staff supported patients with their exercises as instructed by the physiotherapy team.

Staff worked across health care disciplines and with other agencies when required to care for patients. The clinical staff communicated with the community team such as district nursing team and GP as needed prior to patients discharge to ensure they receive continued support. Staff told us that discharge planning was based on a multidisciplinary team approach and assessments of needs.

Seven-day services

The hospital did not provide emergency care and 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, seven days a week. Consultants were available out of hours and at weekends and would attend as needed.

The operating theatres operated six days a week. They also provided emergency service twenty-four hours a day and seven days a week and had an on-call rota. This ensured patients received care and treatment in a timely manner to meet their needs.

Allied health professionals including physiotherapy and radiology provided care and support seven days a week. The pharmacy was available five days a week and the staff had access to the pharmacy out of hours.

Consultants undertook a daily review of their patients an either visited or telephoned the service for an update at weekends.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards. Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients were assessed at the pre admission clinic and advice on smoking risks were discussed. During a pre -admission call prior to surgery, staff advised patients on smoking cessation for at least a few hours prior to admission.

The national Commissioning for Quality and Innovation (CQUIN) for 2019–2020, which encourages hospitals and other settings to deliver alcohol identification CQUIN. This covers activities including alcohol and tobacco

interventions under a prevention of ill health theme. For 2019-20, eighty per cent of patients admitted as a hospital inpatient for one night or more are expected to be 'screened' for alcohol and tobacco use.

The service undertook patients screening for smoking and alcohol and achieved 80% for both alcohol and tobacco screening. The service gave brief advice for 90% of smokers identified and 90% of people who consumed alcohol over the recommended limits received advice or were referred for specialist support.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance and this was clearly recorded. We heard staff gaining verbal consent prior to undertaking any procedure.

Staff told us they did not have patients with advanced dementia. However; they were aware of their responsibilities and staff said they would seek advice if patients could not give consent. They would involve others to ensure decisions were made in their best interest, considering patients' wishes.

Staff made sure patients consented to treatment based on all the information available. The service had a two-stage consent process. Patients records showed consents were clearly recorded and nursing staff competed stage 2 of the consent form on the day of their surgery as part of their pre- operative checklist. Staff had received consent training in order to complete this pathway and records showed this was fully completed.

Are surgery services caring?

Good

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

Compassionate care

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

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Consideration was given during the pre-assessment process to ensure that arrangements were made to meet the diverse needs of patients using the service. The hospital was planning to develop a multi faith room and a designated room to meet the needs of patients who may have a diagnosis of dementia.

The service had an up to date policy on chaperones which they defined as a person who undertook to accompany a patient during a consultation, examination or procedure in order that both the patient and the doctor's/practitioner's interests were protected. Information regarding access to chaperones was available at the service and staff told us patients were offered or had an appropriate person present during examination and treatment.

Patients were positive about their experience of care and treatment they were receiving. People said that staff always provided care that exceeded their expectations. Comments included' the staff do their very best for you'. Another person told us they had been a patient previously and that' the staff are marvellous'. We observed staff on numerous occasions speaking calmly to patients and providing reassurance when they appeared anxious.

The service reviewed their Friends and Family Test responses and had received positive feedback with a recommended percentage of 95 – 100%. This considered how well the service was meeting patients' needs including maintaining privacy, dignity, and well-being at 95%.

Staff followed policy to keep patient care and treatment confidential. Patients who were admitted for eye surgery for example were accommodated in a shared area, as they did not require a bed. Arrangements were in place to

ensure male and female patients were accommodated in separate areas. Patients were taken to a separate room for staff to complete their admission process to ensure patient confidential information was managed sensitively.

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

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed staff giving explanation and reassuring patients in the anaesthetic room and checking that they were all right.

Patients who were admitted for day surgery were supported and staff took time to explain the timing for the procedure and told they would return to the ward after their procedure and that they would ensure their comfort and manage their pain.

In the recovery room patients were involved during the handover, pain was assessed, and patient responded they had no pain. Patient consulted if they were happy to return to the ward and discharge sheet was completed and this was explained to the patient in a calm manner.

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 the support commenced at the pre- operative stage in order to minimise the impact of being immobile for example which can be a major cause of stress for some people. Managers told us consultants would refer patients for psychological support in the community as needed.

Understanding and involvement of patients and those close to them

Staff supported and involved 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 talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Staff supported patients to make informed decisions about their care ensuring they had information in a timely way. Patients who paid for their care had detailed information regarding costs sent to them in advance in order to assist them in their decision.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The patients had access to feedback forms and the service had introduced a new process to ensure people were given the opportunity to provide feedback.

Patients gave positive feedback about the service. We saw numerous thank you cards which included comments praising staff for their support and involving patients in making decisions about their care. Patients who were self-funding were directed to a business manager in order that patients received clear and consistent information regarding the cost of their treatment and payment options.

Are surgery services responsive?

Good

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

Service delivery to meet the needs of local people

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

The hospital leaders were working with local commissioners to alleviate pressure on the wider system and included regular meetings with the local commissioners. The service offered a muscular-skeletal triage service for patients from West Berkshire presenting with hip and knee conditions. The hospital had contacted local GPs to ensure that they were aware that the referral process for orthopaedic surgery had changed and direct referrals were no longer accepted.

. Managers monitored and acted to minimise missed appointments. Managers ensured that patients who did not attend appointments were contacted promptly and their GPs were informed.

The hospital offered outreach clinics for patients. These were consulting rooms where patients could see a consultant locally and then had surgery at the hospital. They also provided a centre for surgery for consortiums of consultants (such as urologists) working privately in their own consulting rooms.

A new cardiology service was being set up. The equipment had been purchased and premises refurbished. Consideration was being given to staffing and the recruitment of technicians to support the new service.

Meeting people's individual needs

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

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Patients individual needs were assessed at the pre- assessment stage and on admission to ensure appropriate support mechanisms were in place.

The service had arrangements in place and could provide information leaflets in different formats. The service had arrangements with an external company to provide information leaflets in different languages. There were hearing loops to support patients with hearing difficulty and information was available in large prints.

The hospital offered their services to private and NHS patients. The service worked with local commissioners and NHS trust to provide coordinated care and meet the needs of people. They had a service level agreement with the local NHS trust to provide elective surgery and endoscopy services.

Privately funded patients had access to treatment by general practitioner (GP) referral or by self-referral for treatment. NHS patients were referred to the hospital by either a GP or an NHS consultant. The hospital offered flexible bookings and short referral times to private patients for their procedure. The NHS patients used the choose and book system which allowed them flexibility and a degree of choice for admission. Patients received a courtesy call from the hospital post discharge to check on their recovery and offered support and advice.

Patients had good access to the service, the main entrance was fitted with large automatic doors, level access, a passenger lift and wheelchair friendly environment which supported patient's independence.

The service worked flexibly to support patient's individual needs. We were told about a patient who was claustrophobic and very anxious about having a magnetic resonance imaging (MRI) scan. An MRI is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body. The patient was invited to visit prior to the scan appointment, to see the scanner and measure it to allow them time to go home and think about how much space there actually was. The patient's relative was supported to remain with them during the procedure.

The service had systems to help care for patients in need of additional support. Staff told us of arrangements they had made to accommodate a patient with a hearing dog to stay with them during their admission. Patients were given a choice of food and drink to meet their cultural and religious preferences and staff knew how to access.

The Patient Led Assessment of the Care Environment (PLACE) for 2019 showed the hospital scored 96% for dementia care. The PLACE assessment took place every year, and results published to help drive improvements in the care environment. The results showed how hospitals were performing both nationally and in relation to other hospitals providing similar services. The dementia section for PLACE looked at wall decoration such as contrasting colours on walls, flooring, pictorial signage, of handrails which can have a positive impact on people living with dementia to navigate around the place. The service was planning to develop a room specifically to accommodate the needs of people living with dementia.

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

Surgery

Between October 2018 and September 2019, the total NHS funded inpatients treated were 361 and 2173 were as day cases. During the same reporting period the service had 286 non-NHS inpatient and 1079 were treated as day cases.

The service had 73 procedures cancelled for non-clinical reason in the last 12 months. All patients were rebooked and offered another appointment within 28 days. The data for compliance to the referral to treatment performance standard (RTT) for December 2019 showed they had achieved 100% compliance for 18 weeks RTT. These included data on urology, trauma and orthopaedic, general surgery, ophthalmology and gynaecology which were the main treatment offered at the service.

The service reported regularly and submitted RTT data to the clinical commissioning group (CCG) as part of their contract.

Patients told us appointments were timely and they were offered choices and the service accommodated their availability for treatment. Feedback from patients were positive and they said they had no difficulties to access appointments. We observed the admission of day care patients and this was well managed, and patients were admitted to the wards in a timely manner.

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 very seriously, investigated them and shared lessons learned with all staff.

The service had an up to date policy and procedure to deal with complaint and staff were able to access this. The policy was last ratified in April 2019. The service undertook a complaint audit in January 2020 and looked at 10 complaints, achieving 89% compliance with audit standards. This showed 100% compliance for information leaflets on how to make a complaint were accessible to NHS and private patients. Letter to acknowledge a complaint and written response within 20 days were at 100%, in line with the provider's policy.

The threshold for reporting feedback as a complaint was low as the organisation was committed to responding and learning from any negative feedback. Patients we spoke with were overwhelmingly positive about their care and treatment and told us they had no complaints.

There was strong governance of complaints with all complaints and negative feedback (such as an overheard comment) being entered on a provider electronic recording system. There was an immediate holding letter sent, setting out the timescale for investigation and a fuller response. A root cause investigation was undertaken and stored on the system. A letter was sent with an apology if there had been any shortfalls in communication or meeting expectations and the person was invited to meet with one of the senior leadership team to attempt to get a complete resolution.

All complaints were reviewed, in depth, at the senior leadership team meetings and were also reported monthly to the head office. Medical complaints were investigated by either the head of department or the head of clinical services in conjunction with the Consultant involved and support from the medical director.

The provider held hospital director meetings for two days, four times a year. The corporate director of clinical services gave a presentation using the information supplied from each hospital to allow consideration of how each hospital performed when compared to other hospitals within the cluster and across the provider.

We were given examples of complaints and their resolution. One example given was about a person who was dissatisfied with the administration following a consultation for elective surgery. They received an apology and went on to have the procedure and gave positive feedback after the operation.

Another example was about a misunderstanding surrounding exclusion criterion set by the Clinical Commissioning Group. They met with the operational director who explained in detail how the criteria were set. They were also offered a meeting with the Hospital Director, as a final step, but had not taken up the offer.

Where complaints were classified as a stage 3 complaint review this was completed by an external independent adjudication service. For private patients in England, Scotland and Wales this was the Independent Healthcare Sector Complaints Adjudication Service (ISCAS). For NHS patients, this was the relevant Ombudsman. A senior manager had confirmed there were no complaints referred to the ombudsman or ISCAS in the reporting period.

Good

Surgery

Are surgery services 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; the Hospital Director provided leadership to a competent senior leadership team. The team, supported by corporate senior staff, understood and managed the priorities and issues the service faced. Both local leaders and the corporate executive team 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 met the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors are fit and proper to carry out this important role. We looked at the senior managers team employment files, which were completed in line with the FPPR regulations.

The hospital had a hospital director who was also the registered manager and in charge of the day to day management of the service. They were well informed about the service, the staff team and the challenges the organisation faced. With the support of the provider, the Hospital Director and leadership team had managed a transformation process that saw improved patient outcomes, stronger governance and better oversight of the financial and activity targets which continued to deliver organisational growth and development.

The senior leadership team met weekly and had a rotating focus for their meetings. There was a four-weekly cycle of focus that revolved through finances, business development, quality and facilities joined with personnel. There was an ongoing action plan that meant that action was decided for each issue raised and the actions were allocated to a designated person. The action plan was then reviewed and updated at each meeting and progress against action plans were assessed.

A business huddle was held each day to consider the hospital's activity levels, the patient flow and any potential challenges to the system. A member of staff from each department attended; usually the person in charge of the department for the day, although the meeting was not hierarchical. Following the meeting, an e-mail was sent with updates, this was available to the entire staff and consultant body. This was printed and displayed at the service which everyone was updated about any changes.

The hospital director and other senior staff were visible and had the respect of the staff group. They were spoken about in a very warm and positive way with staff saying they trusted the hospital director to do the right thing.

We attended a senior leadership meeting which showed a cohesive team approach to the management of the hospital: The senior staff worked well together. As an example, we heard about a potential contract with a medical research company who wanted to lease premises from the provider. There was careful consideration of the potential benefits to both organisations, discussion about the contractual arrangements and due diligence. Timescales were adjusted to ensure that the correct processes and refurbishment had been completed prior to signing off the lease.

Vision and strategy

The provider had a vision for what it wanted to achieve and a strategy to turn it into action. This was underpinned by a local vision and strategy. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The Vision and Strategy were supported by organisational values.

The vision and strategy were displayed on the wards and staff told us about the tree of hands which translated into the six Cs which all staff had signed up to. The clinical strategy incorporated the six Cs of care such as compassion, competence, communication, commitment, care and courage.

Locally, we were told that the vision for the Berkshire Independent Hospital was to be the provider of choice because they believed they delivered high quality outcomes, sustainability, had the best staff and had sustainable services. The hospital senior leadership team

also wanted to work with other local stakeholders to inform and influence the development of services across West Berkshire, Buckinghamshire, Oxfordshire through their commissioning contracts.

The Ramsay Way was;

- We are caring, progressive, enjoy our work & use a positive spirit to succeed.
- We take pride in our achievements and actively seek new ways of doing things better.
- We value integrity, credibility and respect for the individual.
- We build constructive relationships to achieve positive outcomes for all.
- We believe that success comes through recognizing and encouraging the value of people & teams.
- We aim to grow our business while maintaining sustainable levels of profitability, providing a basis for stakeholder loyalty

The provider values were;

- Integrity.
- Ownership
- Positive spirit
- Innovation
- Teamwork

Staff were aware of the vision and values of the service and a senior staff told us that staff were signed up to the vision and what they wanted to achieve. The five key priorities were to improve the focus on patient engagement and becoming partners in their care through patients and carers committee. Staff development and retention, the staff were supporting the apprentiships programme and told us this was a positive step in developing their own staff. The provider was working on strengthening the relationships with stakeholders and commissioners.

Staff told us that they were very proud of the teamwork and team spirit of all of them working together for the benefits of patients.

Culture

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

We found a positive culture with staff saying they respected and trusted the senior leaders. They were committed to delivering good care and enjoyed their work.

Senior leaders were respectful and proud of the hospital team. The hospital director talked about it being as important to care for and value staff as much as the patients. She understood that happy, contented and empowered staff delivered better care more consistently which benefitted patients.

Staff surveys for all employed were managed by the provider. The hospital director told us they were slightly disappointed with the response rate of 53%. The survey was open to bank staff as well as substantive staff, which went some way to explain the response rate.

The three themes that emerged from the survey were around communication, reward and recognition and the visibility of senior leaders (including from head office). No areas were very low scoring.

The hospital managers had responded appropriately to the staff's survey findings and action had been taken. We saw a new recognition tree in the staff dining room. This was a painted tree with paper leaves that anyone could write a positive message on about somebody else. The leaves were then stuck to the tree for all to read. One leaf thanked the member of staff who had painted the tree in their own time.

Corporate staff were regular visitors, with the director of clinical services visiting fortnightly. The CEO had been invited to present the long service awards for staff, recently. The Chief Operating Officer visited every other month. All the corporate team walked around the hospital when they visited and speak to all staff on duty at the time.

All staff nominated for an 'Above and Beyond' award received a letter detailing why they had received the award. and a free lunch voucher.

If the hospital met its activity and financial targets, the entire staff were given a free lunch. This had been aligned to an increased staff awareness of their part in budgetary control and delivery of the activity levels to sustain the business. The hospital finance director met with heads of departments to help them understand their budgets and to allow them to be more involved in decision making. The provider was about to send out a consultant survey.

In April 2015, after engaging and consulting with key stakeholders including other NHS organisations across England, the Workforce Race Equality Standard (WRES) was mandated through the NHS standard contract, starting in 2015/16. From 2017, independent healthcare providers were required to publish their WRES data.

The Berkshire Independent Hospital published its WRES data. There were no trends identified and no issues where responses raised concerns. The hospital had a multi-cultural and multi-ethnic workforce that was valued and respected. The provider was pro- active in using this to develop learning from the WRES data. An action plan was developed which included ensuring WRES principles were reflected in the leadership training. and continue to review current recruitment practices in order to improve participation rates of unconscious bias training.

The WRES data showed 78% of white employee survey respondents believed that the provider offered equal opportunities for career progression or promotion compared to 63% of black and ethnic minority (BME) employees. Action plan from WRES data was developed such as improving access to vacancies and including opportunities for promotion. The provider was introducing a formal talent and succession planning framework for all levels of the organisation. Also, they planned to increase the percentage of managers completing diversity and equality training before undertaking any interviews.

The provider had a speaking up for safetly programme that was based on the professional codes of practice. There was also a promoting professional accountability programme supported by peer messengers. There were several peer messengers at the hospital including consultants. Staff could raise concerns themselves, could speak to their manager or could report using the new service portal. Concerns on the portal went directly to the director of clinical services and their team at the provider's head office. The medical director was also made aware, if the issue involved a consultant. The corporate team dispatched a peer messenger to speak to the person about whom the concerns related to.

An example was given where a nurse had identified concerns about surgeon who wanted to bring a patient back for further surgery within a very short time and had raised it with the head of clinical services(Matron). The patient's file was reviewed, and it became apparent they had been referred as an NHS patient but moved onto a private patient pathway and were self-funding. This begun a wider review that ended with the suspension of the surgeon and an investigation of their integrity along with a peer review of their clinical outcomes. Subsequent to the investigation, the surgeon had their practicing privileges terminated.

Governance

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

There were strong governance systems that were used to monitor the performance of the hospital and to drive improvements. Some of the governance was around the business model, activity and financial management but there was also good local and corporate oversight of patient outcomes and the quality of care.

The hospital senior leaders were supported by visible and accessible corporate staff. There was a system for benchmarking the individual hospital against other hospitals within the group. The benchmarking was shared by the Director of Clinical Services at the hospital directors' quarterly away days. Each hospital director submitted a report to the provider, and these were collated into a single, comparative report.

The senior leadership team meeting was the key governance meeting for the hospital. It took place monthly and gave all senior staff a clear oversight of the hospital's performance, quality and finances along with business planning and organisational development. The meeting we

observed was focussed, well attended and underpinned by accurate and succinct data. There was challenge between participants but also a clear positive and warm senior team culture.

Complaints were routinely presented to the clinical governance committee meeting and the Medical Advisory Meeting (MAC). Complaints and learning from complaints also featured in the monthly governance reports sent to the corporate clinical team for providing 'Ward to Board' transparency and facilitated shared learning across the company.

The Medical Advisory Committee (MAC) was the representative and governance body for the consultants. The chair of the MAC met with the hospital director weekly to discuss any changes or concerns. The committee had representation from each speciality and was the forum for concerns and learning to be shared with the consultants. We saw evidence that the MAC was managed effectively and acted where there were concerns about an individual consultant. The hospital director shared quality outcome data, incident investigation outcomes and complaints data through the quarterly meetings.

Speak up for safety training was presented to the clinical governance and medical advisory committees. From May 2019, 98% of staff employed by the hospital had completed speaking up for safety training. Staff told us this was as part of developing the culture to speak up for safety.

The service had a comprehensive system in place to monitor practising privileges. The granting of practising privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic.

A team reviewed the database regularly to ensure that consultant information was up to date. This included General Medical Council (GMC) registration, appraisals, indemnity insurance, and disclosure and barring service checks. We reviewed three consultant records and these all contained appropriate and up to date documentation.

There were close working relationships with medical directors of neighbouring trust to share any concerns about a doctor's practice. Medical advisory committee (MAC) chair was supported by a corporate medical director.

Most consultants had substantive NHS contracts and were appraised through their employing trust. The appraisal documents were reviewed and stored as part of the consultants personal file. Where a consultant did not have an NHS contract, they were appraised by the Ramsay Healthcare appraisers and monitored by the responsible officer for Ramsay Healthcare.

The human resources co-ordinator monitored the revalidation dates for healthcare professionals and checked the registers to ensure they had completed their revalidation in time and have current registration as required for their practices.

Managing risks, issues and performance

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

The service had an audit plan for the year ahead which clearly set out what audits needed to be completed, when and in what frequency.

The service had systems to manage unexpected events such as power cuts and floods.

The hospital had a clear risk management policy and risk register. The policy set out the process for the identification, assessment and control of risks at all levels across the organisation, including at divisional level. The policy set out how risk should be calculated depending on the impact and likelihood of a risk.

The risk registers for each department were stored on a shared drive so were available to all. The risk register was underpinned by risk assessments that were also stored on the shared drive.

Each department had a risk register. Entries with higher scores were escalated to the hospital risk register and from there, the greatest risks to the corporate risk register. The threshold for escalation was set quite low which meant that any more serious risk was reviewed at hospital or corporate level regularly.

There was only one risk that scored highly enough to be included on the corporate risk register and that was due to be closed at the next meeting. Department heads and the hospital director could discuss the risks and the action taken, in considerable detail.

The three highest scoring risk on the hospital risk register were;

- Staff's awareness of the requirements of information security legislation and the need to be mindful when responding to emails.
- Not having a sterile supplies department on site which meant that a few staff had to push trollies manually onto the delivery vehicles.
- A water quality problem that had now been addressed and was due to be closed.

There were few staff vacancies and no recorded risk around staffing. In addition to internal governance the hospital was monitored by the Clinical Commissioning Groups (CCG) as 65% of their work was with NHS patients. They were subject to the NHS standard contract requirements which set clear expectations around the quality of service and reporting systems. As part of the process specific performance indicators required under the Commissioning for Quality and Innovation (CQUIN) scheme for 2019/2020 must be met. Failure to do so can result in reduced payments. The hospital had met the CQUIN targets for the year to date and received full payment. Additionally, the hospital had exceeded the self-pay target for the preceding year.

The service had reviewed their procedures for on call and contacts for out of hours. There was an on-call rota for overnight and at weekends. The on-call staff included a senior leader, a clinical on-call (band 6 or above). They both telephoned in to the handover sessions and joined the virtual safety huddle. They had good oversight of all the patients and the staff on duty and were able to respond quickly to any changing demands.

The head of clinical services (Matron) was accredited as a trainer to deliver speak up for safety programme to all staff. The aim was to drive a culture of change for all staff to feel safe to 'speak up for safety. Staff we spoke with were positive about the re enforcing this speaking up for safety culture and felt managers were supportive.

One known and ongoing risk was around the potential for consultants to be taking on excessive commitments. There are three independent hospitals in very close proximity plus a large acute trust. This was well managed, and the hospital senior leaders had good oversight of consultant workloads and the performance of individuals. As an example of the oversight, the hospital director met with the practice manager for the local anaesthetic consortium weekly. There was an agreement that the on-call anaesthetists did not also have a surgical list to cover.

Managing information

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

The service had a process whereby external communication were sent by SECURE email or nhs.net to nhs.net. The provider had declared they were compliant with general data protection regulation (GDPR) guidance on consent to communication and the storage of patient information.

Staff were able to access information on their local intranet, which included clinical policies and standard operating procedures. There was also information such as patient information leaflets to support a patient giving informed consent, which staff could print for the intranet. For example, information about joint replacement was available.

The patient, on discharge, received a letter that included details of their surgical procedure, findings, medication and any changes and details of any follow up. The service sent a copy of this letter to the GP and placed a copy in the patient's medical records at the hospital.

The medical staff were able to access patient's information, including scan results and blood tests using the hospitals information technology systems. The service was able to access NHS patients' history such as e records, this had been recently developed. The service had access to provider health information network (PHIN) which enabled them to monitor access to consultant's data. It provided information of adverse events and trends for the service and the wider health economy

Engagement

Good

Surgery

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

The hospital had a well-developed process to engage and to review all feedback from patients and their relatives in order to improve the service provision. There was a patient experience committee with representatives from patients and staff representatives from each department which met quarterly to seek people's experience of care. Action plan were developed, and changes implemented as needed to improve patients' experience and meet their expectations.

The hospital contributed to provider health information network (PHIN). The data March 2019 showed that 96% of patients surveyed said they would recommend the hospital as a place for care and treatment and 92% were satisfied about how they had their needs met.

Patients were encouraged to provide feedback of their care and treatment, and this was well publicised at the service. Each department provided patients with a 'friends and family' feedback form which was completed at the point of care. Patients were also sent an electronic feedback form which gave them the opportunity to provide further feedback in more detail after their care or treatment. Patients feedback were reviewed and shared with staff each month and then on quarterly basis.

As part of an initiative to improve patients' feedback, a staff member had suggested running a competition for the most feedback cards received monthly. The managers told us this had led to an increase in patient feedback responses and staff were rewarded for the highest number of returns.

The service held monthly patient information evening events, in February 2020 this was planned for patients with cataract which will be followed by cosmetics surgery and foot and ankle.

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.

We looked at processes and safety systems introduced following a serious incident in 2017. There were now good systems to mitigate against the risk of recurrence. We were assured that, whilst a similar post-operative complication might arise, the systems put in place and the staff culture of feeling able to raise concerns meant that the appropriate action would be taken, and expert advice would now be sought at a much earlier point.

We saw examples of innovative practice. Some were developed through a corporate quality improvement programme and some were local initiatives that came about in a variety of ways.

The service was planning to change their intravenous infusion pumps for pain relief. Clinical staff at the hospital had developed a drug library of the most common drugs used including intravenous antibiotics, pain medicines and insulin. This had been ratified by the chief pharmacist and anaesthetist. This was due to be presented to the medical advisory committee (MAC) for approval. The ward manager said that once approved, staff would receive training in the use of this new equipment prior to this being introduced at the service.

Consultants working at the hospital offered GP educational events. A session booked for April 2020 was about the diagnosis and management of common shoulder injuries. It included supervised practice of injection techniques.

The service GP liaison officer worked closely with practice managers and GPs at the local practices and surrounding areas. The service undertook continuous professional development (CPD) sessions taking consultants into GP practices to offer training and latest development awareness, as well as running healthcare professional training seminars at the service.

The hospital was committed to alcohol and tobacco screening, this was a focus for 2019/2020 and has been agreed with Berkshire West CCG as one of their CQUINs

The hospital was introducing a surgical sperm retrieval service. Working with urologists from a recognised fertility service, the hospital will be one of very few centres to offer this service.

The hospital had employed a mental health registered nurse and was training them as a mental health first aider. This has been agreed as one of the CQUINs for hospital and would be a focus for 2019/20. The mental health support

role was to promote better understanding and advocate for patients and staff. Having the ability to recognise if someone needed mental health support and guide the person to the relevant help that they may need.

Advanced physiotherapy practitioners were employed to improve outcomes for patients. They worked with spinal patients and those having shoulder surgery. As advanced practitioners, they could carry out ultrasounds, do joint injections and prescribe treatment.

Plans for future business development were discussed with consideration being given to local and corporate funding for a new cardiology service being introduced as well as consideration of the staffing needs and timings for recruitment. There was challenge from within the senior leadership team during the meeting. This included questioning about whether the website had been updated to reflect changes to the consultant body and a discussion about patient records.

Good

Outpatients

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients services safe?

Good

Outpatient services were previously inspected as part of the outpatient and diagnostic services. This is the first inspection, where core services have been separated. Outpatients and Diagnostic services were previously rated as good. We rated it as **good.**

Mandatory training

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

The service followed the corporate mandatory training matrix that confirmed which training subject was required for each staff group. The matrix identified the type of training required; e-learning, face-to-face with an instructor, or a practical session, for example, and set out the timing that an update or review training was required.

Staff in the outpatient's department (OPD) met the 90% compliance target in all subjects. Subjects included health safety and welfare, fire safety, equity diversity and human rights, information security, moving and handling, general data protection regulation (GDPR), dementia awareness, infection control – clinical and adult resuscitation.

Staff told us they received an email from the OPD manager to remind them to complete mandatory training and refresher training and were also reminded in daily huddles and at staff meetings. Staff told us they had enough time to complete their mandatory training.

Safeguarding

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

Safeguarding of children and adults training was undertaken every three years for levels one, two and three. Training was delivered in line with the Ramsay corporate safeguarding of children and young people; safeguarding adults; and intercollegiate documents. Safeguarding training was delivered in face-to-face sessions and in e-learning modules.100% of outpatient staff had completed training in safeguarding adults' levels one and two and safeguarding children levels one and two.

There was an up to date corporate 'Safeguarding Adults Policy Incorporating Mental Capacity and Deprivation of Liberties and PREVENT for England and Wales' and 'Safeguarding of Children and Young People' policy with defined responsibilities at national, regional and hospital level. Prevent is the duty in the Counter-Terrorism and Security Act 2015 by which staff in health care settings must have training to identify ways to prevent people from being drawn into terrorism.

Staff knew who the safeguarding leads were for both vulnerable adults and children, who were trained to level three. The leads cascaded information to staff, assisted with mental capacity act (MCA) assessments and escalated or sought advice from the local safeguarding team as required. The Hospital Director held a current level 5 qualification in safeguarding. Each department had a safeguarding champion whose role was to support staff and patients in raising any concerns.

The hospital did not treat any children and patients were actively discouraged from attending for appointments with children.Staff had completed the necessary level of child safeguarding training but had not had to make any referrals.

The service had access to the Ramsay Health Care UK Ltd group regional safeguarding lead trained to level 4. This was in line with the 'intercollegiate document, safeguarding children and young people: role and competences for health care staff, March 2014'.

We saw that there was information displayed in each department on the actions to be taken and who to contact, in the event of adult or child safeguarding issues arising. Staff knew who to contact if the OPD manager was not available and told us the actions they would take if they suspected a safeguarding incident; this was in line with policy. For example, one staff member told us they had made a safeguarding referral when concerns were raised that an adult was at risk of harm.

Cleanliness, infection control and hygiene

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

The hospital had online policies in place for infection prevention and control (IPC) and hand hygiene. The policies were reviewed regularly and were next due for review in August 2022. There were monthly hospital wide hand hygiene practice audits. The hospital had a lead for infection prevent and control who chaired the IPC committee and provided a route of escalation for risks identified.

Rooms used for clinical procedures were adequately equipped to maintain safety and complied with infection control standards. Appropriate air filtering systems and air changes were in place for the minor operations procedure room.

There were reliable systems in place to protect and prevent people from healthcare-associated infections. Data confirmed there had been no cases of hospital acquired methicillin-resistant staphylococcus aureus (MRSA), Methicillin-susceptible Staphylococcus Aureus (MSSA), C. Diff, E. coli or surgical site infections in the 12 months prior to the inspection.

Audits checked compliance with national hand hygiene standards which included having short nails, being bare below the elbows and hand washing technique. All areas of the hospital score 98% or above and any issues identified had an action plan to make sure they were resolved.

There were clinical handwashing sinks and hand sanitizing gel within the departments we visited. All visitors were prompted to decontaminate their hands on entering the department. Staff followed their corporate 'Hand Hygiene' policy which included types of hand hygiene, soap and water, and wearing of jeweler. Staff in all the departments we visited were observed adhering to 'arms bare below the elbow' guidelines.

Personal protective equipment (PPE), such as gloves and aprons, was readily available for staff in all clinical areas, to ensure their safety and reduce risks of cross infection when performing procedures.

The examination couches seen within the consulting and treatment rooms were visibly clean, intact and made of wipeable materials. This meant the couches could easily be cleaned between patients.

The PLACE assessment for cleanliness for 2019 was 100%, which was better than the organisational average of 98.5%. The assessment of cleanliness covers areas such as patient equipment, baths, showers, toilets, floors and other fixtures and fittings.

Patient-led assessments of the care environment (PLACE) are a system for assessing the quality of the patient environment; patients' representatives go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness, patients living with dementia or disability and general building maintenance.

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 hospital entrance had two automatic doors which kept the waiting area a comfortable temperature. The waiting area was divided into two; one for NHS patients and one for private patients. The area was carpeted, had subtle lighting and background music playing. A

television played an informational video displaying the services of the hospital. The reception desk was fitted with two alarms. One to be used in case of a security concern and the other to summon help if a patient became suddenly unwell.

We observed the area was busy during our inspection and conversations at the reception desk could be overheard from the seats in the waiting area. A sign at the reception desk indicated where patients should wait to give more privacy to patients at the desk. Staff told us that if patients asked to discuss matters in private, they would take them to a vacant consulting room if it was possible to do this, but that patients' privacy could not always be maintained in the departments.

The outpatient service had 12 individual consulting rooms, and three minor procedure rooms, used for minor operations such as lumps and bumps and treatment. There was a dedicated physiotherapy suite with five treatment rooms and two small gymnasiums; all departments were tidy and well equipped.

All rooms were locked when not in use with either keypad or key access. The consulting rooms were tidy and equipped with a desk and chairs for discussions with patients, and a couch area for procedures.

There were 'sharps' bins available in all the consultation rooms and we noted the bins were correctly assembled, labelled, and dated. None of these bins were more than half-full, which reduced the risk of needle-stick injury. This is in accordance with Health Technical Memorandum (HTM) 07-01: Safe management of healthcare waste.

The service had rooms allocated to specialties which were prepared with appropriate equipment for investigations or treatment. This enabled equipment to be easily accessible to reduce waiting time.

The Patient Led Assessment of the Care Environment (PLACE) for 2019, showed the hospital scored 97.9% for condition, appearance, and maintenance, which was better than the organisational average of 96.3%. The assessment for condition, appearance, and maintenance covers areas such as decoration, the condition of fixtures and fittings, tidiness, signage, lighting (including access to natural light), linen, access to car parking, waste management, and the external appearance of buildings and maintenance of grounds.

Staff in the physiotherapy department had competency documents to show they were trained in the use of specialist equipment, this meant the hospital ensured staff were safe and competent to use equipment with patients.

Resuscitation equipment and medicines for adults were available in the department or in adjacent departments. All trolleys had tamper proof locks, and records indicated that the trolleys were checked daily on days when clinics operated. We saw consumables were in date and trolleys were clean and dust free. The automatic electrical defibrillator worked, and suction equipment was in working order.

In line with guidance records showed electrical safety testing was undertaken annually. Staff we spoke to were clear on the procedure to follow if items of equipment were faulty or broken. Legionella testing was completed every three months and pseudomonas testing monthly. Minutes of the infection prevention and control committee confirmed that neither legionella or pseudomonas was detected in the latest water test.

We saw waste was separated and in different coloured bags to signify the different categories of waste. This was in accordance with the HTM 07-01, control of substance hazardous to health (COSHH), health, and safety at work regulations. On the day of inspection, the outdoor waste storage area was unlocked. We informed the staff who immediately locked the area. We checked the outdoor waste storage and it remained locked during the day on inspection.

Fire extinguishers were well maintained and had been assessed as safe and working in the 12 months before inspection.

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.

Systems and procedures were in place to assess, monitor and manage risks to patients. The service always had access to a resident medical officer (RMO), provided by an external provider. The RMO was trained in advanced life support. The RMO provided support to the outpatient

staff if a patient became unwell. Patients identified as being unwell upon arrival to the department were reviewed and patients were referred to the inpatient area for admission when appropriate.

Staff gave us an example of a patient who had become unwell during an outpatient consultation. The patient has been assessed, stabilised and transferred to the local NHS hospital in line with hospital policy.

The hospital used the National Early Warning Score (NEWS 2) for all patients in line with the National Institute for Health and Care Excellence (NICE) guidelines, relating to recognising and responding to the deteriorating patient. This was used to record routine physiological observations such as blood pressure, temperature and heart rate, with clear procedures for escalation if a patient's condition deteriorated. Nursing staff described the process and explained who they would contact in an emergency.

If a patient became generally unwell during a procedure, or whilst they were waiting for treatment, they would be moved to a clinic room and the RMO would take observations and examine the patient. Refreshments were provided for patients whose blood sugar levels were low and hypoglycaemic medications (to raise blood sugar levels) were available on all resuscitation trolleys.

The service followed the corporate "Recognition and Management of the Deteriorating Patient" policy which set out criteria for transferring a patient to a local NHS hospital for higher acuity care, such as level 2 or 3 critical care. Staff described the process and their actions and confirmed they had received training in the recognition of a deteriorating patient.

Sepsis training was part of the mandatory training and all outpatient staff were compliant. The deteriorating patient policy included guidance and treatment pathways for sepsis, such as sepsis six guidance.

The outpatient's service had processes in place to assess the risk to patients using the service and developed risk management plans in line with national guidance. Risk assessments were carried out at pre-assessment and reviewed throughout the patient pathway.

All patients were seen within the national recommended referral to treatment times which minimised the risk of patient harm.

Patients had their bloods taken as required were analysed at point of care testing. Blood tests, such as blood cultures, were sent off-site to a laboratory. Staff could access the test results using an online portal.

All outpatients were under the care of an appropriate consultant who had practicing privileges at the hospital. Practicing privileges ensured that all health and social care professionals involved with patient or client care are qualified, competent and authorised to practice.

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 used a recognised baseline staffing tool to monitor staff levels. Staffing levels across the service were reviewed in advance on a weekly basis and daily within a meeting held each morning with service leads. We observed that patient appointments and staffing levels/ skill mix were reviewed during our inspection. Staff were allocated to clinics according to the activity to ensure patient care was safe.

Staff were appropriately skilled and had completed training relevant for their roles. There were six qualified nurses and four health care assistants who worked in the outpatient department. In the 12 months prior to inspection the hospital had not used any bank or agency qualified nurses to fill shifts. Between 8 and 23% of health care assistant shifts were covered by bank staff.

Staff had a daily team meeting to share important updates such as changes to planned clinics or staffing for the day.

A registered nurse was allocated to both 'corridors' in the main OPD area to ensure safe staffing was maintained at all times. All qualified nurses were trained to support each clinic to provide flex with arranging cover at short notice.

There were no medical staff employed directly by the service, with all consultants working under practicing privileges. Practicing privileges are granted to doctors

who treat patients on behalf of an organisation, without being directly employed by that organisation. All consultants carried out procedures that they would normally carry out within their scope of practice within their substantive post in the NHS. Consultants new to the hospital received a formal induction and could work under practicing privileges only for their scope of practice covered within their NHS work. Details of consultants working at the hospital can be found in the surgery report.

Consultants with practicing privileges were required to be contactable always when they had a medical patient at the hospital or were expected to confirm at least one colleague as cover in their absence. Nursing staff told us that they could call and speak with the consultants at any time for advice if a patient had contacted them with a request to bring forward an appointment, for example.

The hospital director and medical advisory committee (MAC) had oversight of practicing privileges arrangements for consultants. We saw evidence in the MAC minutes of decision-making for renewing or granting privileges.

The hospital had resident medical officers (RMOs) who provided a 24-hour a day, seven days a week service, on a rotational basis. The RMO provided support to the clinical team in the event of an emergency or with patients requiring additional medical support.

There was enough consultant staff to cover outpatient clinics. All staff we spoke with told us they had very good relationships with the consultants and we observed this on the day of the inspection.

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.

Records were kept in both electronic and paper formats. There were policies for clinical record keeping and the security of medical records. We saw that the outpatient and physiotherapy departments stored records safely and securely in line with the Data Protection Act, 1998. We saw all computers were locked when not in use. This prevented unauthorised access and protected patient's confidential information.

All NHS and private patient records were kept in a standardised corporate file. These ensured patient records were always available for clinics. Patient records were recalled from a medical records store in time for the patient's outpatient appointment, or a patient record was set up for new patients. Staff told us if a patient attended clinic without a record being available it was the consultant's decision as to whether they could see the patient safely without records. This had not happened in the 12 months before inspection.

If a consultant wished to take a patient record off site, they were required to confirm would abide by the 'Security of Medical Records outside a Ramsey Health Care Facility IS009' policy.

We reviewed five sets of patient records during the inspection. During the clinics all patient records were kept in a locked cupboard and moved to the clinic room when the patient attended for their appointment.

All staff we spoke with were aware of their responsibilities around the safekeeping of records and confidentiality of patient information. 100% of staff had completed mandatory training in information security and GDPR.

The hospital planned to change to a solely electronic patient record as part of a corporate upgrade during 2020.

Medicines

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

The hospital had a medicines management policy for the safe management of medicines. The policy was reviewed regularly and was next due to be reviewed in September 2022. The purpose of the policy was to make suitable arrangements for the recording, safe-keeping, handling and disposal of drugs.

Consultants were responsible for the prescribing and administering of all medicines for patients attending the service. Patients who were provided with a prescription could have it dispensed by the on-site pharmacy that was available Monday to Friday.

Medicines were supplied by the on-site hospital pharmacy and medication was stored securely in locked

cabinets in rooms that required keypad access. Medicines requiring cool storage were stored appropriately and records showed they were kept at the correct temperature, so would be fit for use.

All medicines stored in cabinets and refrigerators were found to be properly stored in intact packaging and were in date. All medicines cabinets and refrigerators had thermometers and we observed daily temperatures were completed.

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 hospital followed their corporate 'Incident Reporting' policy. The policy had been reviewed regularly and was next due to be reviewed in August 2022. Heads of departments and clinical leads had completed root cause analysis (RCA) training. RCA training was on-going for staff to improve incident reporting, the quality of data provided, and to increase understanding of how incidents happen, and how staff can prevent and/or correct errors.

There were no never events or serious incidents reported in the OPD department during the previous 12 months. 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.

In the reporting period October 2018 to September 2019 the outpatient and diagnostic imaging department had reported 35 clinical incidents and three non-clinical incidents. This data was not reported by individual department.

Staff had received training and told us they were encouraged to report incidents however, not all staff had been required to report an incident. Most staff provided us with examples of feedback following investigations of incidents. Staff told us of an example of practice that has changed following the discussion of an incident. The practice of writing the patient details on blood bottles was changed to putting self-adhesive stickers with the patient details printed on to reduce human error.

All incidents and adverse events were also discussed at the monthly and senior management meetings. We saw minutes that confirmed this. Although the department had a plan to hold monthly staff meetings, they had not held regular minuted staff meetings for the 12 months before inspection.

Staff described the principle and application of duty of candour, Regulation 20 of the Health and Social Care Act 2008, which relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant person) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff were aware of the corporate "Being Open" policy. Patients and their families were told when they were affected by an event where something unexpected or unintentional had happened**.**

Safety Thermometer

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

See information under this sub-heading in the surgery report.

Are outpatients services effective?

We currently do not rate effective for outpatient services.

Evidence-based care and treatment

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

Specialties within outpatient services delivered care and treatment in line with the National Institute for Health and Care Excellence (NICE) and national guidelines where appropriate. New, or recently reviewed NICE guidance, was a standard agenda item and discussed in medical advisory committee meetings.

Policies were up to date and assessed to ensure they did not discriminate based on race, nationality, gender, religion or belief, sexual orientation or age. Staff in outpatients and physiotherapy had a good awareness of and had read local policies. They could give us examples of how to find policies and when they had used them.

The hospital had an audit programme, and collated evidence to monitor and improve care and treatment. We were provided with the local audit programme for the hospital, which was set corporately by the Ramsay Health Care UK Ltd group. The hospital was able to benchmark the results from the audits with other hospitals within the Ramsay Healthcare group. Audits included consent, resuscitation, hand hygiene, health and safety, the World Health Organisation (WHO) safer surgery checklist, and medicines management. We saw evidence that actions were taken to improve compliance where indicated.

Please see the surgery report for further details.

Nutrition and hydration

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

A range of refreshments were available for patients from machines situated in the main reception areas. Private patients had complimentary refreshments and there was a small charge for NHS patients.

Reception staff told us they offered patients who appeared anxious or distressed a drink and helped patients who required additional support to purchase refreshments.

We observed that the patient appointment letter detailed whether patients were able to eat and drink prior to their appointment or scheduled procedures.

The hospital took part in the Patient Led Assessment of the Care Environment (PLACE) audit in 2019, which showed the hospital scored 91.4% for organisational food which was worse than the organisational average of 93.9%.

Pain relief

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

Patients we spoke with had not required pain relief during their attendance at the outpatient departments.

Pain relief was not routinely administered within the service as patients attended for short periods and usually took analgesia prior to attendance. Nursing staff we spoke with told us consultants would normally prescribe relevant pain medication for patients under their care.

Pain advice booklets were provided to patients undergoing minor procedures and GPs were advised of a patient's treatment and prescription plan to support continuity of care on discharge from the outpatient's department (OPD) service.

Patient outcomes

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

The OPD participated in national 'patient reported outcome measures' (PROMs) and in the national joint registry (NJR). Results 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. Outcomes were benchmarked against other comparable services and, where poor outcomes were identified, action plans were in place to improve performance.

Please see the surgery report for further details.

Competent staff

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

Throughout our inspection, we found staff received training to support the delivery of care and individual's developmental needs.

All new employees underwent an induction and competencies were assessed and reviewed as required.

The heads of department confirmed they had assessed staff to ensure they were competent in their role. We saw a competency folder in place which demonstrated staff had been appropriately assessed.

The head of department monitored staff competence and skills. Poor or variable staff performance was identified through complaints, incidents, feedback and appraisal. Staff were supported to reflect, improve and develop their practice through education and one to one meeting with their manager.

Staff within the OPD and physiotherapy department had attended both local, external and corporate courses. These included; dealing with difficult people, effective leadership skills and automated external defibrillator (AED) training. AED training ensured staff had the necessary skills needed to respond to an emergency until medical services arrived.

Evidence showed that 100% of OPD staff had received an appraisal, which were recorded on the corporate electronic recording system. We reviewed five staff appraisals and found them to be fully completed.

Healthcare assistants (HCAs) told us they were supported with development opportunities, one had engaged on registered nurse training and two further HCAs had expressed interest in following this training pathway.

The hospital ensured qualified nursing staff continued to maintain their registration. Information supplied by the hospital showed 100% completion rate of validation of registration for nurses and for doctors working under practicing privileges.

Consultants applying for practicing privileges had to demonstrate their competency prior to undertaking any new procedures in the OPD. This was done by seeking evidence from their NHS practice.

The hospital training plan was reviewed quarterly in heads of departments quarterly meetings.

Multidisciplinary working

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

There was a strong multi-disciplinary team (MDT) approach across all the areas we visited. All staff, clinical and non-clinical, worked alongside each other throughout the hospital. We observed good collaborative working and communication amongst all members of the MDT. Staff reported that they worked well as a team.

Staff told us they were proud of their multidisciplinary team working, and we saw this in practice. Staff were courteous and supportive of one another. Medical and nursing staff reported good working relationships.

Physiotherapists worked collaboratively with OPD and ward staff to ensure patients received a timely and streamlined service.

There was a daily hospital huddle where representatives from all departments attended and were updated on unwell patients, activity, staffing, incidents and social news. Staff told us this improved their relationship with other departments within the hospital.

We observed in patient records that GPs were kept informed of treatments provided; follow up appointments, and medications to take on discharge.

Seven-day services

The outpatient department was open between 8am and 8pm on Monday to Friday and between 8am and 2pm on Saturday.

Please see the surgery report for further details.

Health promotion

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

All hospital staff were encouraged to have a flu vaccination to help reduce the spread of flu between staff and patients.

Physiotherapists provided patients with written exercise regimes to support their rehabilitation within the community.

Please see the surgery report for further details.

Consent and Mental Capacity Act

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

The hospital had a Consent to Treatment for Competent Adults policy which was reviewed regularly. This policy was next due to be reviewed in May 2022. The hospital

had an up to date policy regarding the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) which was next due to be reviewed in December 2020. Staff could access this on the hospital intranet.

The Mental Capacity Act (MCA) protects people who are not able to make decisions and who are being cared for in hospital or in care homes. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Staff completed Mental Capacity Act and Deprivation of Liberty Safeguards training within the safeguarding adult's mandatory training.

The service followed their corporate 'Mental Capacity Policy', which included responsibilities and duties, training, key principles assessing capacity, best interest and refusal to be assessed.

Staff in outpatients and physiotherapy told us they rarely encountered patients with dementia or who lacked capacity. However, they were able to describe the process they would follow if they suspected a patient lacked capacity and knew who to contact for further support or advice on this.

Contact details for the hospital safeguarding lead and the local safeguarding team were displayed in the nurse's office, so staff would know who to contact if they had any concerns.

Initial consent for surgery was completed by the consultant providing care in the outpatient's department. All patients undergoing surgery were consented by the consultant providing care during outpatient consultation. The six patient records we reviewed had consent clearly recorded and documented in writing.

Patients told us they had been given clear information about the benefits and risks of their surgery in a way they could understand before signing the consent form.

Patients said they were given enough time to ask questions if they were not clear about any aspect of their treatment.

Are outpatients services caring?

Good

Outpatient services were previously inspected as part of the Outpatient and Diagnostic services. This is the first inspection, where outpatient and diagnostic services have been separated. Outpatients and Diagnostic services were previously rated as good. We also rated it as **good** in the most recent inspection**.**

Compassionate care

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

Patients were treated with respect and compassion throughout their care within outpatient services. Staff responded kindly and with empathy to queries in a timely and appropriate way. We observed caring interactions with patients whilst they were booking in patients at the main reception or being assisted in the departments. One patient told us "The staff are so helpful and pleasant".

Throughout our inspection, we saw patients were treated with compassion, kindness, dignity, and respect. We received comments such as, "I think they're all excellent. I can't think of anything to improve on", and "This is my third visit to the hospital, and I have not had a bad experience".

Staff respected patients' social, cultural, and religious needs. We observed positive interactions between staff, patients, and relatives. Staff introduced themselves and took time to interact in a considerate and sensitive manner. We observed all reception staff went out of their way to greet patients kindly, and one staff member told us, "The staff here are like a big family and always support each other".

Consulting rooms were fitted with a code-controlled lock. During the inspection we saw staff knock on consulting room doors before entering when patients were in treatment areas and consulting rooms.

The Patient Led Assessment of the Care Environment (PLACE) assessment for 2019 showed the hospital scored 95.3% for privacy, dignity, and well-being, which was better than the organisational average of 88.1%. The

place assessment for privacy, dignity and well-being, focused on key issues such as the provision of outdoor and recreational areas, changing and waiting facilities, access to television, radio and telephones. It also included the practicality of male and female services such as bathroom and toilet facilities, and ensured patients were appropriately dressed to protect their dignity.

The hospital obtained patient feedback in several ways. The Friends and Family Test (FFT), enabled patients to submit feedback using a simple question which asked how likely, on a scale ranging from extremely unlikely to extremely likely, they were to recommend the service to their friends and family if they needed similar care or treatment. From June to November 2019, monthly scores were 100%. Response rates ranged from 22 to 88% of patients per month.

There were posters in reception and around clinical areas with details about how patients could provide feedback or complain. Friends and family test cards were freely available for patients to complete. The service used a 'We value your opinion' survey and a patient satisfaction survey to review the service.

Emotional support

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

Staff had a good awareness of patients with complex needs and those patients who may require additional support, should they display difficult behaviours during their visit to outpatients.

Patients we spoke with told us they knew who to contact if they had any worries about their care and said staff had supported them emotionally as well as physically, where there had been bad news following diagnostic results.

Staff told us they had time to spend with patients and their families to provide whatever emotional support they needed.

Understanding and involvement of patients and those close to them

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

Throughout our inspection, we observed staff introduced themselves to patients and explained their treatment and care options.

We saw appointment letters, which contained clear information about appointments and what to expect. Booking administrators sent information about how to get to the hospital and specialist information depending on which clinic they were attending. All patients told us they were provided with a good, clear explanation and most were provided with written information about their condition.

There was a wide range of written information about treatments and health promotion in the waiting areas. Information on the treatments and services the hospital provided was also available on the hospital website. Self-funding patients had information about the cost of their treatment and payment options.

All outpatient services offered patients a chaperone and departments clearly displayed signs in waiting areas and consulting rooms. Patients were given the opportunity to be accompanied by a friend or relative and there were chaperones available when personal care was provided. For example, female nurses or healthcare assistants were available to act as chaperones when required. There was a policy in place for offering chaperones in the outpatient department. Staff had completed training and were aware of their responsibilities for providing chaperone support. The policy was reviewed regularly and was next due to be reviewed in August 2021.

Are outpatients services responsive?

Good

Outpatient services were previously inspected as part of the Outpatient and Diagnostic services. This is the first inspection, where core services have been separated. Outpatients and Diagnostic services were previously rated as good. We rated it as **good.**

Service delivery to meet the needs of local people

Good

Outpatients

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

The service reflected the needs of the population and provided flexibility, choice, and continuity of care. Patients attending the hospital OPD were a mix of privately funded and NHS funded patients. These patients had chosen the hospital as a location for their appointment through the NHS e-referral service.

The service had good working relationships with the local clinical commissioning group to manage services for NHS patients. This meant that local commissioners were involved in the planning of local services.

The OPD and physiotherapy departments offered early and late appointments, as well as appointments on Saturdays. Patients could also telephone for advice outside of their appointment times.

The OPD clinics and physiotherapy department were clearly signposted, and staff directed patients to the relevant areas.

The physiotherapy department had a separate waiting area that was appropriate for the services that were planned. The service provided a range of classes in the gym to suit patient's needs, which included group and individual classes. The classes were held in the afternoons and evenings and included provision for people with a sports injury.

Where possible, the service provided one stop clinics where all investigations, diagnosis, and treatment planning were carried out in one day.

The hospital had limited car parking facilities which impacted on the needs of patients during times of increased activity. Patients spoken with confirmed that parking at the hospital could, at times, be difficult. Parking was free and the hospital continued to review all options and had created some additional parking spaces.

General information leaflets relating to most services provided, including complaints, were also available in the waiting areas.

See information under this sub-heading in the surgery report section.

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 identified the communication needs of people with a disability or sensory loss at the referral or initial appointment stage.

Patients were provided with a leaflet, "How we communicate with you" which explained how the service would store and use their personal information in patient records. Patients were given an option to confirm how they wished the service to communicate with them for example, by telephone, email, text message.

The service provided appropriate translation services, hearing assistance, sign language interpreters or other assistance to ensure the individual needs of the patient were considered.

Patients told us that they were given detailed explanations about their admission and treatment as well as written information. The department had a stock of accessible information which included easy to read, large print and alternative languages.

A range of refreshments were available for patients in the main reception areas.

High-back chairs were available in most waiting areas to accommodate older patients or those with mobility issues. There were no bariatric examination couches in the outpatient department. There was a bariatric couch in the theatre department which could be used if needed.

There were procedures in place to make sure patients who were self-funding were aware of fees payable. Staff told us they would provide quotes and costs and aimed to ensure that patients understood the costs involved. Leaflets were available that explained the payment options, and procedures and gave advice of who to contact if there were any queries. The hospital website also clearly described the different payment options available. Information was also displayed on notice boards to inform patients that additional costs may be incurred in some circumstances.

The admissions process had been reviewed to ensure the services delivered were accessible and responsive to people with complex needs. This included identifying patients with mental health needs or those living with

dementia. All staff were supported to complete dementia awareness training. The hospital has recently employed a mental health nurse who would provide support for dementia patients, patients with learning difficulties and supporting the mental health of staff and patients.

Staff gave us an example of a patient with learning difficulties who was supported to fill in paperwork by the mental health nurse. Plans to support patients with a diagnosis of dementia included coloured pillow cases to identify a patient may need extra support and creating 'forget me not' boxes.

Patient Led Assessment of the Care Environment (PLACE) for 2019 showed the hospital scored 96.5% for dementia, which was better than the organisational average of 81.5%. The place assessment for dementia was included for the first time in 2015, and focuses on key issues such as, flooring, decoration (for example contrasting colours on walls), signage, along with seating and availability of handrails, which can prove helpful to people living with dementia.

Patient Led Assessment of the Care Environment (PLACE) for 2019 showed the hospital scored 95.2% for disability, which was better than the organisational average of 83.1%.

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.

There were 5705 NHS funded patients who attended the outpatient department for their first appointment from December 2018 to November 2019. There were 6233 NHS funded patients who attended the outpatient department for follow up in the same period.

There were 2255 patients who were funded either from insurance or self-pay schemes who attended the outpatient department for their first appointment from August 2017 to July 2018. There were 3349 of this group of patients who attended the outpatient department for follow up in the same period.

Patient access and flow was discussed at a daily '10 at 10' meeting. This included all senior staff members. The number of new and follow-up clinic appointments, and the number of patients undergoing minor treatment were discussed. The meeting enabled key safety information to be shared with each department, identified any risks to the service, for example staff sickness, and enabled information to be cascaded to staff across the department each morning.

Patients could book appointments on the NHS 'Choose and Book' portal that provided patients with a choice of appointment time. Private patients could book appointments through the centralised team or the website, and bookings administrative staff screened referrals and referred to the appropriate specialism.

Access to outpatient appointments was fast and patients told us they were more than satisfied with the amount of time it had taken to obtain an appointment. Patients also told us they were able to book appointments at times that suited them. Access to physiotherapy services was fast and group classes meant appropriate patients could begin sessions in a timely way.

Appointments were available at weekend clinics according to clinical need.

On arrival, patients reported to the receptionists who logged them in via an electronic booking system and directed them towards the appropriate clinics and waiting areas.

The hospital had a low rate of patients not attending appointments. All patients who missed an appointment had their referring doctor informed.

See information under this sub-heading in the surgery report section.

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.

Staff we spoke to were aware of the complaint's procedure. We saw complaints leaflets were available throughout the hospital; complaints could be made in person, by telephone, and in writing by letter or email.

Good

Outpatients

Staff said that if a patient raised a concern or wanted to make a complaint, they would try to resolve it locally to prevent escalation. Where this was not possible the complaint was referred to the head of department or manager. All complaints resolved locally were recorded on their internal electronic system and would be escalated further as required. Complaints were an agenda item on team meetings.

Senior managers were all involved in the management and investigation of patient complaints. The hospital acknowledged complaints within 48 hours of receiving the complaint, with an aim to have the complaint reviewed and completed within 20 days. There was an expectation that complaints would be resolved within 20 days. If they could not, a letter was sent to the complainant explaining the reason that additional time may be required for further investigation.

New complaints and learning from complaints were discussed at relevant committee meetings including monthly clinical governance team meetings, medical advisory committee meetings and heads of department meetings. Learning from complaints was cascaded to staff in the department in regular huddles and within team meetings.

See information under this sub-heading in the surgery report section.

Are outpatients services well-led?

Good

Outpatient services were previously inspected as part of the Outpatient and Diagnostic services. This is the first inspection, where core services have been separated. Outpatients and Diagnostic services were previously rated as good. 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 service was part of the Ramsay Health Care UK group. The senior management team reported to the corporate leads and were supported through a network of regional and national leads and specialists.

The hospital was led by a hospital director, a site operations manager, a finance manager and head of clinical services (matron). Heads of department or leads were in place for each specialty and service. At a department level staff reported to the heads of department, including the outpatients' and physiotherapy manager.

The senior leadership team met weekly and had a rotating focus for their meetings. There was a four-weekly cycle of focus that revolved through finances, business development, quality and facilities joined with personnel. There was an ongoing action plan that meant that action was decided for each issue raised and thee actions were allocated to a designated person. The action plan was reviewed and updated at every meeting.

All staff felt they could be open with colleagues and managers and told us they could raise concerns and would be listened to. Staff said any inappropriate behaviour would be dealt with immediately.

Departmental action plans gave ownership to heads of departments to ensure that objectives were cascaded to staff at all levels. Progress was regularly reviewed through the heads of department committee meeting and departmental meetings.

Staff said the hospital director and head of clinical services (matron) were well respected, and always available and supportive when required. Managers encouraged learning and a culture of openness and transparency. They operated an 'open door policy' and encouraged staff to raise concerns directly with them. We saw senior managers visiting the outpatient's department during our inspection. Staff told us this was a normal occurrence.

Senior staff were supported to attend corporate leadership programmes and additional training relevant to their role. Succession planning concerned the identification of staff with strong qualities to complete future leadership programmes.

See information under this sub-heading in the surgery report section.

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.

We were told that the vision for the Berkshire Independent Hospital was to be the provider of choice because they believed they delivered high quality outcomes, sustainability, had the best staff and had sustainable services. The hospital senior leadership team also wanted to work with other local stakeholders to inform and influence the development of services across West Berkshire, Buckinghamshire, Oxfordshire through their commissioning contracts.

The OPD and physiotherapy undertook audits of patient records, and infection, prevention and control that aimed to continuously improve patient care, in line with the hospital-wide vision and strategy.

Staff were aware of the hospital vision in delivering high standards of care and were aware of the strategy with 'growing' the service in areas. Staff were proud of the job they did and aimed to provide safe and high-quality care.

See information under this sub-heading in the surgery report 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.

We found the culture across the service aligned with the corporate culture, "Our Culture – The Ramsay Way". This set out statements concerning the organisation's cultural values that included: 'We are caring and progressive, enjoy our work and use a positive spirit to succeed. We aim to grow our business while maintaining sustainable levels of profitability, providing a basis for stakeholder loyalty. Working together - We believe that success comes through recognising and encouraging the value of people and teams. We build constructive relationships to achieve positive outcomes for all. We value integrity, credibility and respect for the individual. We believe that success comes through recognising and encouraging the value of people and teams. We take pride in our achievements and actively seek new ways of doing things better.'

Staff described the culture at the hospital as being open and honest and felt they were listened to by senior managers.

Many staff had worked in the organisation for many years and there was a high staff retention rate. Staff said they felt valued by managers and colleagues.

The nursing team, consultants, physiotherapy team and administration team communicated well together and supported each other.

We saw that the culture of all the areas we visited during our inspection centred on the needs and experiences of the patients. For example, if a mistake happened this was handled in a sensitive and open way.

All staff we met were welcoming, friendly and helpful. They were proud of where they worked and said they were happy working for the service. We observed staff practice and saw that they were polite and professional with all patients and families.

Managers had a good knowledge of performance in their areas of responsibility and they understood the risks and challenges to the service.

Governance

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

The service had clear governance systems that ensured there were structures and processes of accountability to support the delivery of good quality services. The service reported directly to the senior leadership team with clear lines of escalation in place. The outpatient department aimed to meet monthly. Discussions at the meeting fed into the wider hospital governance structure.

Senior OPD staff attended meetings through which governance issues were addressed. The meetings included Medical Advisory Committee (MAC), Senior Management, Heads of Department (HoDs), Clinical Governance Committee, and Infection, Prevention and Control Committee meetings. Minutes were descriptive and were circulated to the wider team for information. There was a list of attendance and an action log to monitor progress against identified actions. Feedback from these meetings was provided to staff during team meetings.

The HoDs met monthly and the minutes showed items discussed included complaints, clinical governance, audit results, and key departmental feedback. These meetings also shared staff experiences and information was shared back with staff in the departments.

Staff members were clear on their objectives and understood how they contributed to the hospital success. Heads of departments identified training needs of staff through appraisal and supported training at the Ramsay Health Care UK Ltd group training academy.

Managing risks, 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.

We saw there was a risk assessment process in place and that identified risks were assessed using a standardised template which scored the risk as low, medium or high risk. The local risk registers were managed by the heads of departments who escalated risks to the senior leadership team. Leaders within the outpatient department could tell us the risks on the departmental risk register. The top three risks were identified as maintaining information confidentiality, decanting liquid nitrogen and the phlebotomy service and displayed for staff to see in the office.

The risk register was discussed as part of the service performance review meeting. Staff described their understanding of what constituted as a risk and were confident they would raise any concerns that they believed impacted on safe patient care.

The service manager had systems and processes which supported monitoring of performance and issues. We observed they had access to an online system to monitor for example; training compliance and equipment maintenance.

Any performance issues or concerns were escalated through monthly departmental review meetings held between the heads of department , clinical lead, hospital director and finance director.

There was a programme of internal audits used to monitor compliance with policies such as hand hygiene, health and safety and cleaning schedules. Audits were completed monthly, quarterly or annually by each department depending on the audit schedule. Senior staff confirmed results were shared at relevant meetings such as clinical governance meetings.

The hospital participated in national audits including the National Joint Registry, Patient Reported Outcome Measures (PROMS) and Patient Led Assessment of the Environment (PLACE).

See information under this sub-heading in the surgery report.

Managing information

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.

Relevant staff could access NHS and private patient electronic records appropriate to the needs of the investigation being completed.

Computers were password protected and locked when not in use. We saw that computers were not accessible to patients.

Good

Outpatients

See information under this sub-heading in the Surgery report section.

Engagement

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

Senior leaders were very respectful and proud of the hospital team. The Hospital Director talked about it being as important to care for and value staff as much as the patients. She understood that happy, contented and empowered staff delivered better care more consistently.

Staff surveys for all employed were managed by the provider. The Hospital Director was slightly disappointed with the response rate of 53%. The survey was open to bank staff as well as substantive staff, which went some way to explain the response rate.

The three themes that emerged from the survey were around communication, reward and recognition and the visibility of senior leaders (including from head office). No areas were very low scoring.

The hospital managers had responded appropriately to the findings and action had been taken. We saw a new Recognition Tree in the staff dining room. This was a painted tree with paper leaves that anyone could write a positive message on about somebody else. The leaves were then stuck to the tree for all to read. One leaf thanked the member of staff who had painted the tree in their own time.

Patients were regularly asked to complete satisfaction surveys on the quality of care and service provided. We saw there were boxes throughout the hospital to place completed forms. The hospital also gathered patient opinion from the friends and family test (FFT), and patient led assessment of the care environment (PLACE). Departments used the results of the survey to improve the service. Patient could also post feedback on-line on NHS choices and social media sites.

Staff recognition schemes included service recognition awards for staff who had worked at the hospital for five, ten, 15, 20 and 25 years.

The hospital organised a variety of activities to improve the well-being of their staff. Staff could be nominated for an award from the hospital manager that recognised exceptional practice, there was a staff running club and the cafeteria offered a national diet club meal as an option at lunch time as staff were following a diet club plan.

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 culture of continuous staff development across the departments. We heard of examples of staff being supported to complete a range of qualifications including an associate practitioner studying a nursing apprenticeship course.

Most staff reported the hospital supported innovation, with the executive team responsive to requests and suggestions for improvement.

We looked at processes and safety systems introduced following a serious incident in 2017. There were now good systems to mitigate against the risk of recurrence. We were assured that, whilst a similar post-operative complication might arise, the systems put in place and the staff culture of feeling able raise concerns meant that the appropriate action would be taken, and expert advice would now be sought at a much earlier point.

We saw examples of innovative practice. Some were developed through a corporate quality improvement programme and some were local initiatives that came about in a variety of ways.

Consultants working at the hospital offered GP educational events. A session booked for April 2020 was about the diagnosis and management of common shoulder injuries. It included supervised practice of injection techniques.

Advanced physiotherapy practitioners were employed to improve outcomes for patients. They worked with spinal patients and those having shoulder surgery. Their qualifications meant they could carry out ultrasounds, do joint injections and prescribe.

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are diagnostic imaging services safe?

Good

Diagnostic services were previously inspected as part of the Outpatient and Diagnostic services. This is the first inspection, where core services have been separated. Outpatients and Diagnostic services were previously rated as good. We rated it as **good.**

Mandatory training

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

The service followed the corporate mandatory training matrix that confirmed which training subject was required for each staff group. The matrix identified the type of training required; e-learning, face-to-face with an instructor, or a practical session, for example, and set out the timing that an update or review training was required.

Staff in the diagnostic imaging department met the 90% compliance target in all subjects. Subjects included health safety and welfare, fire safety, equity diversity and human rights, information security, moving and handling, general data protection regulation (GDPR), dementia awareness, infection control – clinical and adult resuscitation.

Staff told us they received an email from the diagnostic imaging manager to remind them to complete mandatory training and refresher training and were also reminded in daily huddles and at staff meetings. Staff told us they had enough time to complete their mandatory training.

We saw evidence that radiographers had read the local rules, employer's procedures and had received training on radiation risk where appropriate.

The consultant radiologists, working for the hospital under practising privileges, did not receive mandatory training from the service. They received training from their substantive place of employment and the hospital kept a record of their completed training. Practising privileges is an established process within independent healthcare where a consultant radiologist is granted permission to work in an independent hospital in the range of services, they are competent to perform.

Full details of training compliance across the hospital can be found within the Surgery report.

Safeguarding

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

Safeguarding of children and adults training was undertaken every three years for levels one, two and three. Training was delivered in line with the provider's corporate safeguarding of children and young people; safeguarding adults; and intercollegiate documents. All safeguarding training was delivered in face-to-face sessions and e-learning modules. 100% of diagnostic imaging staff had completed training in safeguarding adults' levels one and two and safeguarding children levels one and two.

There was an up to date corporate 'Safeguarding Adults Policy Incorporating Mental Capacity and Deprivation of Liberties and PREVENT for England and Wales' and 'Safeguarding of Children and Young People' policy with

defined responsibilities at national, regional and hospital level. Prevent is the duty in the Counter-Terrorism and Security Act 2015 by which staff in health care settings must have training to identify ways to prevent people from being drawn into terrorism.

Staff knew who the safeguarding leads were for both vulnerable adults and children, who were trained to level three. The leads cascaded information to staff, assisted with mental capacity act (MCA) assessments and escalated or sought advice from the local trust's safeguarding team as required. The Hospital Director held a current level 5 qualification in safeguarding.Each department had a safeguarding champion.

The service had access to the Ramsay Health Care UK Ltd group regional safeguarding lead trained to level 4. This was in line with the 'intercollegiate document, safeguarding children and young people: role and competences for health care staff, March 2014'.

We saw that there was information displayed in each department on the actions to be taken and who to contact, in the event of adult or child safeguarding issues arising. Staff knew who to contact if the radiology manager was not available and told us the actions they would take if they suspected a safeguarding incident; this was in line with policy. For example, one staff member told us they had made a safeguarding referral when concerns were raised that an adult was at risk of harm.

The hospital did not treat any children and patients were actively discouraged from attending for appointments with children. Staff had completed the necessary level of child safeguarding training but had not had to make any referrals.

Radiographers told us that should they suspect physical abuse when reporting images, they would escalate their concerns to their manager or senior management team.

Cleanliness, infection control and hygiene

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

The hospital had online policies in place for infection control and prevention (IPC) and hand hygiene. The policies were reviewed regularly and next due for review in August 2022. There were monthly hospital wide hand hygiene practice audits. The hospital had a lead for infection prevent and control who chaired the IPC committee and provided a route of escalation for risks identified.

Rooms used for clinical procedures were adequately equipped to maintain safety and complied with infection control standards.

There were reliable systems in place to protect and prevent people from healthcare-associated infections. Data confirmed there had been no cases of hospital acquired methicillin-resistant staphylococcus aureus (MRSA), Methicillin-susceptible Staphylococcus Aureus (MSSA), C. diff, E. Coli or surgical site infections in the 12 months prior to the inspection.

Audits checked compliance with national hand hygiene standards which included having short nails, being bare below the elbows and hand washing technique. All areas of the hospital scored 98% or above in December 2019 and any issues identified had an action plan to make sure they were resolved. There was handwashing sinks and hand sanitising gel within the departments we visited. All visitors were prompted to decontaminate their hands on entering the department. Staff followed their corporate 'Hand Hygiene' policy which included types of hand hygiene, soap and water, and wearing of jewellery. Staff in all the departments we visited were observed adhering to 'arms bare below the elbow' guidelines.

Personal protective equipment (PPE), such as gloves and aprons, was readily available for staff in all clinical areas, to ensure their safety and reduce risks of cross infection when performing procedures. Equipment was marked with 'I am clean' stickers following decontamination. Ultrasound probes used for intimate examinations underwent the correct decontamination process according to the hospital policy.

The examination couches seen within the consulting and treatment rooms were visibly clean, intact and made of wipeable materials. This meant the couches could easily be cleaned between patients.

Patient-led assessments of the care environment (PLACE) are a system for assessing the quality of the patient environment; patients' representatives go into hospitals

as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness, patients living with dementia or disability and general building maintenance.

The PLACE assessment for cleanliness for 2019 was 100%, which was better than the organisational average of 98.5%. The assessment of cleanliness covers areas such as patient equipment, baths, showers, toilets, floors and other fixtures and fittings.

The hospital's infection control processes were coordinated and led by the infection prevention and control (IPC) nurse. The IPC committee comprised of a consultant microbiologist, IPC lead, head of clinical services, pharmacy link and theatre manager. The minutes identified representation and links from the x-ray department. Meetings were held quarterly and provided the hospital with infection prevention advice and guidance in conjunction with Ramsay Health Care infection prevention and control policies and procedures and national guidance.

The hospital had hand hygiene dispensers and 'bus stop' hand gel stations which we saw in place. Hand gel dispensers were available in waiting areas with visible signage to encourage staff and visitors to use them.

Equipment was cleaned after each use to ensure it was ready for the next patient. We observed the ultrasound being cleaned after each procedure and the couch was prepared for the next patient with clean paper. Ultrasound probes used for intimate examinations underwent the correct decontamination process according to the hospital policy.

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.

There was a radiation protection policy which was regularly reviewed, and the radiation protection officer carried out audits that demonstrated compliance with the Ionising Radiation Regulations 2017 (IRR 17).

The services provided included x-rays, ultrasound and MRI scanning, a fluoroscopy room and dual energy x-ray absorptiometry (DEXA) scanning. A DEXA scan is a type of x-ray that measures bone mineral density.

Records showed electrical equipment in the departments had been portable electrical appliance tested and that radiology and other equipment was serviced regularly under contractual arrangements with the suppliers.

Patients attending the department reported initially to the reception area where a member of the diagnostic team then called the patient into the department for their investigation.

We saw evidence that quality assurance testing was completed at regular intervals in line with the Institute of Physics and Medical Engineering (IPEM). We saw the annual report for 2019 with no issues or concerns identified.

The x-ray service used the resuscitation trolley located in the outpatient's department while the MRI areas had access to their own resuscitation trolley. The anaphylaxis (an acute allergic reaction) boxes which staff accessed in an emergency, were available and in date. These were well equipped and maintained, with daily checks recorded. We found no issues or concerns with the daily or weekly checklist recordings.

We saw that all imaging rooms were clearly signposted with "do not enter" warning lights to ensure that staff or patients did not enter rooms whilst imaging was taking place. This was in line with the Medicines and Healthcare Products Regulatory Agency (MHRA) guidance for access.

Staff had access to appropriate personal protection equipment (PPE), including lead gowns and neck shields. The radiology department had clear guidelines on which specialised PPE should be used for specific procedures. PPE was routinely checked to ensure it was not damaged.

The service stored hazardous substances appropriately and in accordance with the Control of Substances Hazardous to Health Regulations 2002 (COSHH). COSHH is the law that requires employers to control substances that are hazardous to health. We saw up to date COSHH risk assessments to support staff's exposure to hazardous substances.

Clinical waste was sorted and disposed of in appropriate, foot-operated waste bins. Sharps disposal bins were labelled correctly and not overfilled and did not appear to contain inappropriate waste.

The equipment faults log was not kept up to date and the last entry was from August 2018. Equipment servicing

records were incomplete and not up to date. Although the radiology equipment had been serviced there was no record of a handover sheet from the engineer to the staff at the end of the service. This was discussed with the newly appointed senior leader during the inspection who attributed this to an issue with the previous managers in post. There was an action plan in place to resolve these problems.

Fire extinguishers were well maintained and had been assessed as safe to use in the 12 months before inspection.

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.

We saw policies were in place to support staff in their role in responding to patient risk. The policy for patient identification and imaging procedures was reviewed and updated in 2018 following guidance from the department of health. For example; the head of department had up to date files in line with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R 17) procedures, as well as standard operating procedures as required under the regulations. The policies would be in final version within four weeks of the inspection.

The service had a designated radiation protection supervisor (RPS) which was in line with the Ionising Radiation Regulations 2017 (IRR17). The RPS's role ensured the service's adherence to safe working practices and what actions to take in an emergency. The contact details for the named RPS was not displayed as an easy reference for staff in the diagnostic imaging department.

Local rules as required under IRR17 required employers to keep exposure to ionising radiation dosage as low as reasonably practicable. The purpose of the local rules was to assist the RPS in instructing staff in radiation protection, and, in the event of an accident, to provide a clear reference to prepared contingency plans.

All staff wore radiation badges to monitor any occupational doses. The service was compliant with the assessment and the recording of radiation doses as recommended under IRR17.

There were signs in the radiology department to denote where radiation exposure occurred to ensure that patients and staff only entered when it was safe to do so.

Senior staff from the diagnostic service attended the daily "ten at ten" meeting which provided the opportunity to discuss any concerns which included for example; planned activities, staffing issues and any equipment or maintenance concerns. Feedback from the meeting was discussed with staff which ensured they could assess and respond to patient risk as appropriate.

Staff also wore radiation exposure devices which were analysed to ensure that staff were not over exposed.

Most patients attending the imaging department were fit and mobile. Those patients that were unwell, were usually inpatients and accompanied by a ward nurse, and if necessary, the resident medical officer (RMO). Most patient risk assessments were completed by the pre-admission service or the referring consultant. However, the radiology service routinely assessed the risk the investigation posed when the patient attended their appointment. Staff had undergone scenario training in January 2020 to practice dealing with a suddenly unwell patient undergoing a scan.

Patients attending the imaging service were required to complete an extensive checklist prior to the investigation to ensure that all risks had been identified to reduce any potential consequential harm.

Imaging staff were aware of the need to risk assess patients prior to each investigation and knew how to escalate any concerns they may have. There were standardised processes to assess risk used within each modality, based on national guidance. For example, the form used to refer patients to the radiology department included a safety check to ensure there was no risk that the patient might be pregnant before undergoing radiation exposure. There were also signs around the radiology department to alert female patients of childbearing age to tell staff if they might be pregnant. Radiographic imaging and MRI during pregnancy might cause harm to the developing foetus and we saw a checklist which was used to assess any potentially pregnant patient prior to the investigation being completed.

Staff in the radiology department used patient pathways and the National Safety Standards for Invasive

Procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs) safety checklist for patients undergoing interventional radiology and scans to ensure that the right patient got the right scan or procedure at the right time. We reviewed four sets of notes for patients who had attended the radiology department and found that checklists had been appropriately completed and recorded.

Investigations were requested using a paper referral system, which was signed by the consultant, and detailed the patient's demographics and outlined the investigation requested. This referral card was used by imaging staff to confirm the patient's identity when attending for their investigation.

Referrals were reviewed by imaging staff to ensure that the correct procedure was being requested. To safeguard the patient, a search was completed of the database to identify if the investigation had been completed at an alternative location. This process prevented patients being exposed to radiation unnecessarily. Radiographers told us that they would enquire with the referring consultant if they had any queries or concerns regarding the requested procedure.

Patients were asked to confirm identity prior to an investigation being completed. Information relating to the patient's name, address, date of birth and expected investigation was discussed between the patient and the member of staff looking after them.

Staff checked that patients who required a contrast media were not allergic prior to administration. Contrast media is used to increase the differences of structures or fluid within the body and was administered by the radiologist responsible for the patient.

The service could access the image exchange portal (IEP) for the safe and secure transfer of picture archiving and communication system (PACS) held images across a national network. The service could "blue-light" any request to receive prioritisation of information if required.

Radiology 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 hospital had an electronic rostering management system that enabled managers to effectively manage rotas, staffing requirements, skill mix and senior cover. The imaging service ensured they had appropriately trained imaging staff to maintain patient safety.

The service monitored the staffing levels daily and weekly to ensure there were safe staffing levels to meet the number of patients seen and to ensure the service manged their individual needs.

The imaging service flexed their time to cover the needs of patients attending the service. Staff confirmed they could call on the services of the resident medical officer when required. Bank radiographers used were familiar with the service and were given an induction to the department. This ensured that radiographers met key requirements such as having completed mandatory training.

The radiation protection supervisor and MRI lead radiographer were new to their posts but felt well supported to carry out their roles. The service had a process in place and all new staff including agency staff followed a full induction prior to starting work.

See additional information under this sub-heading in the Surgery Report section.

Medical staffing

The service had enough radiologists with the right qualification, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

There were no radiologists employed directly by the service, with all radiologists working under practising privileges. All radiologists carried out procedures that they would normally carry out within their scope of practice within their substantive post in the NHS. Radiologists new to the hospital received a formal induction and could work under practising privileges.

All consultants were requested to provide documented evidence of an annual appraisal so that it could be used as part of their revalidation process.

Good

Diagnostic imaging

The service had 16 radiologists working within the hospital. For radiologists to acquire and maintain practising privileges radiologists were required to produce evidence annually of their professional registration, revalidation, indemnity insurance, appraisal, mandatory training and continuous professional development.

There was a small group of radiologists working within the service to facilitate reporting on images. These were regular staff, who attended the hospital on set days according to their availability. Staff told us that if their specialist knowledge was required, they could be contacted directly.

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.

Diagnostic images were archived using an electronic database and were password protected to prevent unauthorised access. Images could be shared with external systems if necessary, which was useful when a specialist opinion was required.

Computers were locked when not in use. This prevented unauthorised access and protected patients' confidential information.

We looked at four patient records which we found to be well maintained. Entries were dated and signed by the appropriate staff member which included details of all investigations and their findings.

The service could access an image exchange portal which allowed them to exchange imaging information with other colleagues which included other providers and consultants.

Medicines

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

The imaging department used a small number of medicines for investigations. These were largely contrast media. We saw these were stored in locked cupboards within the diagnostic imaging service.

Radiologists were responsible for the prescribing of all medicines for patients attending the service. Radiographers with the appropriate skills and competence were responsible for administering medicines required for imaging.

During the inspection we found all medicines were in date.

Detailed findings on medicines can be found in the surgery report.

Incidents

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

There was a policy for incident reporting, which was in date. The policy identified everyone's responsibilities for reporting and investigating incidents. Staff described when they would report an incident and the process used. Incidents were investigated and discussed during staff meetings. We saw minutes of meetings that confirmed this.

There were no never events or serious incidents reported in the diagnostics department. 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.

All incidents involving radiation were reported on the hospital's incident reporting system. These were categorised as 'IR(ME)R' incidents for data collection and trend monitoring. The hospital reported all radiation errors to the radiation protection advisor. Senior staff and radiographers explained and demonstrated the processes to be followed for radiation incidents.

Staff in diagnostic imaging used an electronic system to report all incidents and in the reporting period October

Good

Diagnostic imaging

2019 to September 2020, there were 177 clinical incidents reported across the hospital. Out of these, 35 clinical incidents had occurred in outpatients and diagnostic and imaging.

All reported clinical incidents had been investigated and we saw evidence of incidents being investigated and learning being shared within the team.

In the diagnostic imaging department, there were clear processes for reporting incidents about the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). There were three incidents involving ionising radiation that had been reported: they were all investigated appropriately and had resulted being classified as no harm incidents.

The hospital had a "being open" policy which provided guidance for staff when patients were involved in an incident by ensuring that, if a mistake was made, patients and/or their relatives/carers received promptly the information they needed to enable them to understand what happened. Radiographers spoken with understood their responsibilities regarding the duty of candour legislation. They said they were open and honest with patients and applied this to all their interactions. Radiographers said they would discuss any identified concerns with the patient and provide a full apology.

Are diagnostic imaging services effective?

Diagnostic services were previously inspected as part of the Outpatient and Diagnostic services. This is the first inspection, where core services have been separated. Outpatients and Diagnostic services were previously inspected but not rated. We currently do not rate effective for Diagnostic Services.

Evidence-based care and treatment

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

Policies, procedures and protocols seen to manage patient's safety were up to date. Policies were referenced against national guidance to ensure care and treatment was delivered in line with legislation, standards and evidence-based guidance.

The service worked to the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R 2017 (IRR17) and guidelines from the National Institute of Care Excellence (NICE), the Royal College of Radiologists (RCR) and other national bodies. This included all specialities within diagnostics.

Radiation Exposure/diagnostic reference levels (DRL) were audited regularly. Staff showed us audits of these which demonstrated that radiation doses to patients were kept as low as reasonably practicable. During the inspection it was noted there was no diagnostic reference levels displayed in the fluoroscopy room for the radiographer to refer to. This was brought to the attention of the radiographer in charge on the day of inspection.

There was a defined audit schedule which the service completed and audited regularly. These covered topics such as record keeping and care of the environment. Most staff were aware of the results for their areas and could tell us about measures the service had undertaken to improve compliance. Staff referred us to folders within the staff room which highlighted evidence of audits and their results.

The hospital had adopted and implemented the National Safety Standards for Invasive Procedures (NatSSIPs). A NatSSIP supports the hospital to provide safer care and reduce the number of patient safety incidents related to invasive procedures in which surgical never events can occur. We saw the radiology departments and its staff had developed and embedded local NatSSIPs to evidence safe practice and reinforce patient safety.

See additional information under this sub-heading in the Surgery Report section.

Nutrition and hydration

Patients had access to a drink when visiting the service.

Patients were provided with clear instructions in their preparation letter about the amount of fluid to drink prior to attending the imaging department. If patients had to fast, they had access to a water fountain in reception to quench their thirst after their procedure.

Patients were given a drink and a biscuit after their intervention procedure. We observed staff checking on patients to ensure they were safe to leave the hospital after their procedure.

See information under this sub-heading in the surgery report section.

Pain relief

The service managed patients' pain effectively.

Pain relief was not routinely administered within the service as patients attended for short periods and usually took analgesia prior to attendance. Radiology staff we spoke with told us consultants would normally prescribe relevant pain medication for patients under their care.

We observed staff asking patients if they were comfortable during their procedure for example; ultrasound scans.

See information under this sub-heading in the surgery report section.

Patient outcomes

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

The diagnostic imaging department audited annually against IR(ME)R standards and completed a Radiology Protection audit (RPA).

The diagnostic imaging department collected information on images that had been rejected, as the image quality meant they could not be used. We were told that this information was made available to the radiation protection adviser, who could review trends in the number of rejected images and, if deemed appropriate, put in place actions to reduce the number.

All radiology reports were audited for compliance with the reporting times. Reports were all completed within 48 hours. A designated staff member oversaw this process and discussed the audit results with the radiologists. This ensured that a robust system was in place to prevent unverified reports causing delay to patient care.

Please see core service report for surgery for main details.

Competent staff

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

The manager monitored staff's competence. Poor or variable staff performance was identified through complaints, incidents, feedback and appraisal. Staff were supported to reflect, improve and develop their practice through education and one to one meeting.

The radiation protection supervisor (RPS) received training every five years from the radiation protection advisor's organisation. The RPS had recently been appointed and had not yet attended the training.

All staff administering radiation were appropriately trained to do so. Those staff that were not formally trained in radiation administration were adequately supervised in accordance with legislation set out under IR(ME)R 2017.

We saw evidence that all radiographers had in date health care professional registration (HCPC). This was in line with the society of radiographers' recommendation that radiology service managers ensure all staff are appropriately registered. Training specific to their registration was reviewed during staff appraisals, along with any development plans.

Staff confirmed the hospital supported staff training and development with staff apprenticeships, mentorship and preceptorship.

Staff said they could request external training courses with training being approved specific to individual's development plans and scopes of practice. Staff confirmed there was good access to additional training and found the hospital very proactive in encouraging staff to attend additional training.

Diagnostic imaging

The manager confirmed they had assessed staff to ensure they were competent in their role. We saw a competency folder in place which meant staff had been appropriately assessed.

Newly appointed radiographers underwent assessments of their competency and we saw completed records maintained by the radiology department manager.

Senior management told us that radiologists applying for practising privileges had to demonstrate their competency prior to carrying out procedures in radiology. Staff also said that any existing radiologist wishing to undertake new procedures had to demonstrate competency. This was done by reference to their NHS practice.

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 saw that the imaging team worked closely with the visiting radiologists. If there were unexpected findings following a radiology imaging, the radiographers contacted the referring clinician and the radiographers followed up on the results to ensure if any further action was needed it was completed.

Staff told us that they could contact their peers working across the Ramsay hospital group for support and advice when required. Heads of departments met to share ideas and work together on consistent approaches to the delivery of care across the Ramsay group.

A radiologist attended the medical advisory committee and local departmental meetings.

Seven-day services

There was a six-day service provided by the imaging service with an on-call provision for any urgent referrals outside this time.

The imaging department provided a service every Monday to Friday 8:30am to 8pm and Saturday 8:30am to 1pm. Outside these hours, imaging could be obtained through an on-call system.

The resident medical officer (RMO) was available seven days a week. The RMO liaised with consultants as to the provision of care for patients when they were not in the hospital.

Health promotion

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

See information under this sub-heading in the surgery report section.

Consent and Mental Capacity Act

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

The hospital had a Consent to Treatment for Competent Adults policy which was reviewed regularly. This policy was next due to be reviewed in May 2022. The hospital had an up to date policy regarding the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) which was next due to be reviewed in December 2020. Staff could access this on the hospital intranet.

The Mental Capacity Act (MCA) protects people who are not able to make decisions and who are being cared for in hospital or in care homes. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Staff completed Mental Capacity Act and Deprivation of Liberty Safeguards training within the safeguarding adult's mandatory training.

The service followed their corporate 'Mental Capacity Policy', which included responsibilities and duties, training, key principles assessing capacity, best interest and refusal to be assessed.

Patients attending the imaging department were required to give consent for their procedure. This was usually in the format of verbal consent for investigations such as x-rays. Staff in diagnostic imaging told us they rarely encountered patients with dementia or who lacked capacity. However, they were able to describe the process they would follow if they suspected a patient lacked capacity and knew who to contact for further support or advice on this.

Good

Diagnostic imaging

The radiologist responsible for an invasive investigation obtained consent from the patient following a detailed account of the investigation process. We did not see any of these procedures during the inspection, and therefore we were unable to confirm the consent practice was being completed appropriately.

See information under this sub-heading in the surgery report section.

Are diagnostic imaging services caring?

Good

Diagnostic services were previously inspected as part of the Outpatient and Diagnostic services. This is the first inspection, where core services have been separated. Outpatients and Diagnostic services were previously rated as good. We rated it as **good.**

Compassionate care

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

We observed imaging staff caring for patients with compassion and understanding. We saw that all staff introduced themselves to patients, gave details of their name and ensured that they knew what they were attending the department for.

Staff promoted privacy, and patients were treated with dignity and respect. Patients were called from the waiting room and staff used this time to talk to patients and put them at ease. We observed staff talking to patients in a respectful and considerate way. For example, we saw both administration staff and radiographers responding compassionately to a patient's emotional distress when attending the service.

The hospital focused on patient feedback to gather data from patients about their experience and satisfaction with the services they have received. In the reporting period October 2019 to September 2020 data showed that from 98 to 100% of patients would recommend the hospital in the friends and family test. Response rates varied from 22 and 88% of patients attending the hospital.

In 2019, the hospital's PLACE score for privacy, dignity and well-being was 95%. This was better than the organisational average of 88%. There was a policy for privacy and dignity; this was due for review in November 2022. We found that staff acted in accordance with this policy at all times when caring for patients.

Emotional support

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

Staff showed awareness of the emotional and social impact that a person's care, treatment or condition would have on their well-being.

Staff understood the emotional stress of patients having a procedure. Imaging staff were not routinely involved with providing support for specific illnesses but could refer patients to their consultant or the head of clinical services if they felt that additional support was required.

Patients said staff quickly responded to their needs and talked openly with them and discussed any concerns. One patient said, "I really like the hospital and can't fault the staff" and others said staff were "really friendly" and "always available to answer any concerns."

Understanding and involvement of patients and those close to them

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

Patients said they felt involved with decisions about their care and treatment and had been asked for permission and agreement which meant that the views and preferences of patients were considered. Radiologists and radiographers gave advice regarding investigation reports and explained that they would need to see the referring consultant for further information.

Patients and relatives confirmed they had been given the opportunity to speak with the consultant looking after them. Patients said the consultants had "explained everything" and that they were fully aware of what was happening. All patients were complimentary about the

way they had been treated by staff. We observed staff introduced themselves to patients and explained to patients and their relatives about the care and treatment options.

Patients who were paying for their treatment privately, told us that the costs and payment methods available had been discussed with them before their admission.

Are diagnostic imaging services responsive?

Good

Diagnostic services were previously inspected as part of the Outpatient and Diagnostic services. This is the first inspection, where core services have been separated. Outpatients and Diagnostic services were previously rated as 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.

Patients attending the hospital's imaging services were a mix of privately funded and NHS funded patients (these patients had chosen the hospital as a location for their appointment through the NHS e-referral service). This meant that there were several patients who attended the service for an investigation without a private consultation.

Radiology and scanning services were clearly signposted and staff directed patients to the relevant areas.

The radiology departments offered early and late appointments as well as appointments on Saturdays. X-rays appointments could be offered as early as the day of referral. For other procedures, depending on the preparation and speciality, an appointment would be offered within the next two working days.

The reception area in the main building was spacious and had large windows overlooking the hospital gardens. Conversations at the reception desks could be overheard from the seats in the waiting area. However, there was a sign at the reception desk indicating where patients should wait to give more privacy to patients at the desk. Staff told us that if patients asked to discuss matters in private, they would take them to a vacant consulting room if it was possible to do this, but that patients' privacy could not always be maintained. To improve the responsiveness of the hospital to patient's needs and as part of the refurbishment the hospital was looking at expanding or re-locating the existing radiology department.

Where possible, the service provided imaging appointments in conjunction with the patient's outpatient consultant appointment.

The hospital had confirmed that limited car parking facilities impacted on the needs of patients during times of increased activity. Patients spoken with confirmed that parking at the hospital could, on times, be very difficult.

See information under this sub-heading in the Surgery report section.

Meeting people's individual needs

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

The waiting rooms had changing areas for the diagnostic services which provided patients with privacy. Patients were seen one at a time, which prevented waiting for appointments in gowns and promoted dignity.

The service provided, when required, a translation services, hearing assistance, sign language interpreters or other assistance to ensure the individual needs of the patient were considered.

Patients told us that they were given detailed explanations about their admission and treatment as well as written information. Staff confirmed that written information could be obtained in other languages if required.

Patients were sent information about any procedure they were having prior to their visit. We saw evidence of ultrasound guided biopsy leaflets and guidance for

liquids to be taken prior to their appointment time. However, unless requested, the information seen was not available in other languages where English was not the patient's first language unless requested.

Staff confirmed that they were usually aware if the patient attending the service had mental health needs or other additional needs such as a learning disability or dementia. All staff were supported to complete dementia awareness training. The hospital has recently employed a mental health nurse who would provide support for patients with a diagnosis of dementia, patients with learning difficulties and supporting the mental health of staff and patients.

The service worked flexibly to support patient's individual needs. We were told about a patient who was claustrophobic and very anxious about having a magnetic resonance imaging (MRI) scan. An MRI is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body. The patient was invited to visit prior to the scan appointment, to see the scanner and measure it to allow them time to go home and think about how much space there actually was. The patient's relative was supported to remain with them during the procedure.

Staff explained that should a patient become anxious or restless during a procedure they would use distraction and de-escalation techniques to calm patients.

The main waiting area for MRI, and DEXA scanning had reading material and a television to occupy patients whilst they waited for their appointment. A DEXA scan is a type of x-ray that measures bone mineral density. There was a clock so patients could keep track of time.

Although the waiting areas were small, they were large enough to accommodate wheelchairs. We were told that when patients required a wheelchair or assistance to mobilise, staff would assist them into the imaging areas.

There were patient toilets located within the departments. These were suitable for the use of patients who had reduced mobility and required mobility aids or wheelchairs.

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.

Patients attending the department attended the main reception areas where they were would be either directed to the MRI area or remain in the main X-ray area. A member of the diagnostic team called the patient for their investigation.

X-rays and ultrasound reporting were completed by the specialist radiologist. Images for ultrasound scans and mammography at one stop clinics were reported at the time of the investigation. All other images were reported on by the specialist radiographer within one week of the image being taken.

The hospital had a very low 'Did not attend' rate. All patients who missed their appointment were followed up and this was audited. Subsequently, the referrer was notified of the non-attendance of their patient.

There were no waiting lists for the imaging service as all scans were offered in line with turnaround times. The hospital informed us that turnaround times for private patients were within 48 hours and NHS cases within seven working days.

Report turnaround times were recorded and if these were below the provider's benchmark, there was a written action plan in place with completion dates. Report turnaround times were recorded monthly and report turnaround times, and action plans (if applicable) were included in the radiology manager's monthly report to the senior management team. The December 2019 NatSSIPS audit showed the service had achieved 100%.

Referral to treatment time is the term used to describe the period between when a referral for treatment is made and the date of the initial consultation or treatment. The diagnostic imaging test waiting times for patients waiting six weeks or more from referral to a diagnostic test from October 2019 to September 2020 was 0%.

For x-rays, appointments could be offered as early as the day of referral. For other procedures, depending on the preparation and speciality, an appointment would normally be offered within three to five days and reported back to the referring clinician as soon as possible.

Good

Diagnostic imaging

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.

Staff we spoke to were aware of the complaint's procedure. We saw complaints leaflets were available throughout the hospital; complaints could be made in person, by telephone, and in writing by letter or email.

Staff said that if a patient raised a concern or wanted to make a complaint, they would try to resolve it locally to prevent escalation. Where this was not possible the complaint was referred to the head of department or manager. All complaints resolved locally were recorded on their internal electronic system and would be escalated further as required. Complaints were an agenda item on team meetings.

Senior managers were all involved in the management and investigation of patient complaints. The hospital acknowledged complaints within 48 hours of receiving the complaint, with an aim to have the complaint reviewed and completed within 20 days. There was an expectation that complaints would be resolved within 20 days. If they could not, a letter was sent to the complainant explaining the reason that additional time may be required for further investigation.

New complaints and learning from complaints were discussed at relevant committee meetings including monthly clinical governance team meetings, medical advisory committee meetings and heads of department meetings. Learning from complaints was cascaded to staff in the department in regular huddles and within team meetings.

Patients who we spoke with told us they did not have any reason to complain during their appointment and said they would feel confident in raising a concern or complaint if necessary. Radiographers said that if a patient raised a concern or wanted to make a complaint, they would try to resolve it locally to prevent escalation. Where this was not possible the complaint was referred to the head of department or manager.

There had been one complaint against the radiology service from June to December 2019. This related to a patient who had not received an appointment for the requested scan. We reviewed this complaint and it had been dealt with in line with the hospital policy.

See information under this sub-heading in Surgery.

Are diagnostic imaging services well-led?

Good

Diagnostic services were previously inspected as part of the Outpatient and Diagnostic services. This is the first inspection, where core services have been separated. Outpatients and Diagnostic services were previously rated as good. We rated it as **good.**

Leadership

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

There was clear leadership within the team. The head of department worked clinically in addition to completing management tasks and duties. Radiographers spoke positively about the leadership of the team.

The manager ensured the diagnostic service understood the IR(ME)R regulations to follow best practice.

Staff said the hospital director and head of clinical services (matron) were well respected, visible and always available and supportive when required.

The senior leadership team met weekly and had a rotating focus for their meetings. There was a four-weekly cycle of focus that revolved through finances, business development, quality and facilities joined with personnel. There was an ongoing action plan that meant that action was decided for each issue raised and these actions were allocated to a designated person. The action plan was reviewed and updated at every meeting.

Imaging staff said they enjoyed working in the department and felt supported by their departmental manager who was accessible and had an open-door

policy. The departmental manager spoke with pride about the work and care their staff delivered daily. Many staff working in the imaging service had worked in the organisation for many years. They told us they had stayed in the organisation for a long time because they enjoyed working together as a team.

See information under this sub-heading in the surgery report section.

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.

We were told that the vision for the Berkshire Independent Hospital was to be the provider of choice because they believed they delivered high quality outcomes, sustainability, had the best staff and had sustainable services. The hospital senior leadership team also wanted to work with other local stakeholders to inform and influence the development of services across West Berkshire, Buckinghamshire, Oxfordshire through their commissioning contracts.

The hospital had a strategy whose values aimed to put "people at the HEART of all we do." The hospital had incorporated the six clinical core values (6Cs) which were: commitment, courage, communication, care, compassion and competence.

Imaging staff were aware that there was a vision and strategy, although did not refer to it directly. Staff referred to changes within the service which were aligned to the vision and strategy. For example, the reconfiguration and expansion of the services were aligned to the five-year strategy.

See information under this sub-heading in the surgery report 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.

We found the culture across the service aligned with the corporate culture, "Our Culture – The Ramsay Way". This set out statements concerning the organisation's cultural values that included: 'We are caring and progressive, enjoy our work and use a positive spirit to succeed. We aim to grow our business while maintaining sustainable levels of profitability, providing a basis for stakeholder loyalty. Working together - We believe that success comes through recognising and encouraging the value of people and teams. We build constructive relationships to achieve positive outcomes for all. We value integrity, credibility and respect for the individual. We believe that success comes through recognising and encouraging the value of people and teams. We take pride in our achievements and actively seek new ways of doing things better.'

Staff described the culture at the hospital as being open and honest and felt they were listened to by senior managers. Many staff had worked in the organisation for many years and there was a high staff retention rate. Staff said they felt valued by managers and colleagues. The diagnostic imaging team communicated well together and supported each other.

We saw that the culture of all the areas we visited during our inspection centred on the needs and experiences of the patients. For example, if a mistake happened this was handled in a sensitive and open way.

All staff we met were welcoming, friendly and helpful. They were proud of where they worked and said they were happy working for the service. We observed staff practice and saw that they were polite and professional with all patients and families.

Managers had a good knowledge of performance in their areas of responsibility and they understood the risks and challenges to the service.

Diagnostic imaging staff we met with were welcoming, friendly and helpful. It was evident that staff cared about the services they provided and told us they were proud to work at the hospital. Staff were committed to providing the best possible care to their patients.

Good

Diagnostic imaging

Imaging staff said they felt valued and supported to deliver care to the best of their ability. They confirmed opportunities to develop their skills and competencies was encouraged by senior staff.

Openness and honesty were encouraged at all levels and staff said they felt able to discuss and escalate concerns without fear of retribution. When incidents had caused harm the duty of candour was applied in accordance with the regulation.

Imaging staff were enthusiastic about their jobs and the team in which they worked. Staff told us that they "loved working at the hospital." Quotes from staff included, "the team work well together" and "everyone is friendly." Staff also confirmed they enjoyed working with their patients and we observed good interaction during the inspection.

Team meetings were consistent every month. We saw staff signed to say they had read the minutes which were informative and provided guidance to staff on a range of topics which included; training, incidents and compliments.

Governance

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

There were structures and processes of accountability in place to support the delivery of good quality services. The service reported directly to the senior leadership team with clear lines of escalation in place.

The manager attended the local clinical governance committee and heads of department meetings. Minutes seen showed that a standardised format was used which looked at incidents and audits undertaken and their outcomes. Minutes were descriptive and were circulated to the wider team for information. There was a list of attendance and an action log to monitor progress against identified actions. Feedback from these meetings was provided to staff during team meetings.

Radiographers had access to the radiation protection advisor (RPA) service and confirmed they acted upon the annual report with any identified recommendations.

Staff attended the radiation protection and medical exposure committee meetings. The minutes had a set agenda which included: a review of previous actions and a summary of ongoing and new actions, a governance report which reviewed incidents and lessons learnt and the review of policies. The service manager confirmed they received relevant information from their line manager. Radiographers spoken with confirmed senior managers provided them with information relevant to their role and the service during staff meetings. Staff told us that meeting minutes were also shared across all Ramsay hospitals.

See information under this sub-heading in the surgery report section.

Managing risks, issues and performance

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

The imaging service maintained a local risk register. Risks identified were recorded on a standardised template which scored risks as low, medium or high risk. We saw that the risk register was reviewed regularly, and any actions taken to mitigate risks recorded.

We spoke to senior staff about risks within their service and confirmed the risk register was discussed as part of the service performance review meeting. Imaging staff described their understanding of what constituted as a risk. The top three risks identified as information safety, MRI magnetic exposure and ionising radiation exposure.

The service manager described the systems and processes which supported the monitoring of performance and issues. They told us they had access to an online system to monitor for example; training compliance and equipment maintenance. We saw folders within the staff room to support staff's knowledge of performance within the imaging service.

Good

Diagnostic imaging

Any performance issues or concerns were escalated through monthly departmental review meetings held between the heads of department, clinical lead, hospital director and finance director. Most of the audits seen had an identified action plan to improve performance.

See information under this sub-heading in the surgery report section.

Managing information

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

Staff could access patient electronic records appropriate to the needs of the investigation being completed. Computers were password protected and locked when not in use. We saw that computers were not accessible to patients.

The imaging service had access to the picture archiving and communication system (PACS) which allowed the acquiring, storage and transmission of radiological films. This meant that films installed onto the PACS system were filed, managed appropriately and could be accessible day and night for viewing.

The imaging service used the radiology information system (RIS). RIS is an electronic management system for the management of medical imagery and associated data. The RIS system was used to track patient scheduling and performance tracking. The RIS system was used in conjunction with the PACS system.

Statuary notifications were submitted to external organisations as required by law.

See information under this sub-heading in the Surgery report section.

Engagement

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

Senior leaders were very respectful and proud of the hospital team. The Hospital Director talked about it being as important to care for and value staff as much as the patients. She understood that happy, contented and empowered staff delivered better care more consistently.

Staff surveys for all employed were managed by the provider. The Hospital Director was slightly disappointed with the response rate of 53%. The survey was open to bank staff as well as substantive staff, which goes some way to explain the response rate.

The three themes that emerged from the survey were around communication, reward and recognition and the visibility of senior leaders (including from head office). No areas were very low scoring.

The hospital managers had responded appropriately to the findings and action had been taken. We saw a new Recognition Tree in the staff dining room. This was a painted tree with paper leaves that anyone could write a positive message on about somebody else. The leaves were then stuck to the tree for all to read. One leaf thanked the member of staff who had painted the tree in their own time.

The staff engagement group worked with the senior management team and hospital staff by holding regular forums to ensure staff were kept informed and had the opportunity to ask questions. We saw information was passed on to imaging staff by the manager through regular team meetings.

For detailed findings on engagement please see the Well-led section of the surgery report.

Learning, continuous improvement and innovation

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

Imaging staff felt they could approach other experienced staff for advice and support when required and said they had picked up valuable skills and awareness by working with colleagues who had such knowledge and expertise.

Most staff reported the hospital supported innovation, with the executive team responsive to requests and suggestions for improvement.

Good

Diagnostic imaging

We looked at processes and safety systems introduced following a serious incident in 2017. There were now good systems to mitigate against the risk of recurrence. We were assured that, whilst a similar post-operative complication might arise, the systems put in place and the staff culture of feeling able raise concerns meant that the appropriate action would be taken, and expert advice would now be sought at a much earlier point.

We saw examples of innovative practice. Some were developed through a corporate quality improvement programme and some were local initiatives that came about in a variety of ways.

Consultants working at the hospital offered GP educational events. A session booked for April 2020 was about the diagnosis and management of common shoulder injuries. It included supervised practice of injection techniques.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital had recently employed a mental health nurse to provide support for people living with a diagnosis of dementia, patients with learning difficulties and supporting the mental health of staff and patients. This had recently been introduced at the service and the provider will be evaluating the impact on this on patients and staff.

Areas for improvement

Action the provider SHOULD take to improve

- The service should update the asset register of the radiation protection supervisor to include equipment in theatres.
- The service should review the equipment fault log in radiology is kept up to date.
- The service should develop a process for the diagnostic reference levels exposure factor charts are displayed in the diagnostic imaging department.
- The hospital should review their external clinical waste storage area, and this is kept secure.
- The service should continue to assess and develop infection control measures and planned replacement of flooring of carpeted areas.