# CircleReading

## Quality Report

100 Drake Way
Reading
Berkshire
RG2 0NE
Tel: 01189226899
Website: https://www.circlehealth.co.uk/reading/

Date of inspection visit: 25 June 2019
Date of publication: 24/10/2019

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.

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

CircleReading is an independent hospital. Facilities include five operating theatres, outpatient and diagnostic facilities.

We inspected this service using our comprehensive inspection methodology and undertook an unannounced inspection of the service on 25 June 2019.

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 surgery – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery service level

Our rating of this hospital stayed the same. We rated it Good

We found the following areas of good practice:

- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.
- The service had a realistic strategy for achieving their priorities which included delivering good quality, sustainable care. There was evidence that progress was measured against this strategy monthly by the senior leadership team
- Results from the Friends and Family Test were good. For example, in May 2019 results showed that 97% of patients and visitors would extremely likely or likely recommend the service to their friends and family.
- Patient healthcare records showed staff considered patient's personal, cultural, social and religious needs and how they may relate to care needs.
- Staff always took time to interact with patients and those close to them in a kind and respectful manner. Patients reported feeling well cared for and having confidence in the team treating them.
- The provider carried out observational audits of theatre practice in respect of the World Health Organisation (WHO) Five Steps to Safer Surgery Checklist. The results of audits were used to ensure ongoing compliance with best practice guidance and to drive improvements.
- The environment was very well maintained and appropriate for the services being delivered.
- There was an extremely positive culture and staff reported feeling happy in their work and well supported by their managers.

However

- In the outpatient department, patient healthcare records were not always completed fully and were difficult to read.

**Professor Edward Baker**
**Chief Inspector of Hospitals**

## Overall summary

# Summary of findings

Circle Reading has 30 inpatient beds with 20-day case pods plus eight ambulatory day case chairs. The hospital has five operating theatres, three of which have laminar flow. There is an endoscopy suite within the theatre complex, as well as a suite of consulting and treatment rooms, and an imaging department offering x-ray, ultrasound and scans. The hospital also has a pharmacy on site.

Circle Reading provides a range of medical, surgical and diagnostic services to patients who pay for themselves, are insured, or are NHS funded patients. Services offered by the hospital include orthopaedics, spinal, general surgery, gynaecology, ENT, ophthalmology, endoscopy, physiotherapy and diagnostic imaging.

We inspected this service using our comprehensive inspection methodology and undertook an unannounced inspection of the service on 25 June 2019.

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 surgery – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery service level.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Surgery** | Good | Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.<br><br>The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff usually used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.<br><br>Staff completed and updated risk assessments for each patient and removed or minimised risks.<br><br>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.<br><br>Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. The service made sure staff were competent for their roles.<br><br>The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patient's subject to the Mental Health Act 1983.<br><br>Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.<br><br>Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.<br><br>Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. |

# Summary of findings

The service was selective to ensure that they were able to meet the needs of individual patients. For the patients' that met the acceptance criteria their individual needs and preferences were considered.

The service had a system for reporting and managing patient safety incidents. Staff felt able to report incidents and sufficiently confident to speak out when things went wrong.

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.

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 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.

## Outpatients

Good

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

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 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 service had enough nursing staff with the right qualifications, skills, training and experience to keep

# Summary of findings

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

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

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately.Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

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

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

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 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.

However,

Staff did not keep detailed written records of patients' care and treatment. Some patient records were very difficult to read.

The WHO Surgical Safety Checklist was not always completed for outpatient procedures. Subsequent to the inspection, the provider ensured that the checklist was used in the outpatient department.

# Summary of findings

## Diagnostic imaging

Good 

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

The service had enough allied health professionals and 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.

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

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

The service provided care and treatment based on national guidance and evidence-based practice. To support the service, there was a Radiation Protector Advisor, a radiation protection supervisor and a medical physics expert for the department.

Radiographers, radiologists, the radiography assistant, administration staff and other health professionals at the hospital worked together as a team to benefit patients.

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

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

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 patient individual needs and preferences.

# Summary of findings

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 with all staff. The service included patients in the investigation of their complaint.

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

Staff 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.

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.

# Summary of findings

## Contents

Good

# Circle (Reading Hospital)

**Services we looked at**
Surgery; Outpatients; Diagnostic imaging.

# Summary of this inspection

## Background to CircleReading

CircleReading opened in August 2012. It is an independent sector hospital in Reading, Berkshire. The hospital primarily serves the communities of Berkshire and the surrounding areas. It also accepts patient referrals from outside this area. The main provision is surgery, specialities treated include: orthopaedics, spinal, general surgery, gynaecology, ENT, refractive eye surgery and endoscopy. The hospital also provides cosmetic surgery, diagnostic imaging and outpatient services.

The registered manager had been in post since April 2019.

## Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, and three specialist advisors with expertise in this type of healthcare provision. The inspection team was overseen by Amanda Williams interim Head of Hospital Inspection.

## Why we carried out this inspection

We carried out this inspection as part of our schedule of comprehensive inspections.

## How we carried out this inspection

Prior to the inspection visit we reviewed all the information we held about the provider and asked for comments from stakeholder agencies. We made an unannounced inspection visit in June 2019 to inspect three core services, surgery, outpatients and diagnostic and imaging services.

Whilst on site we spoke with staff of all grades and disciplines, spoke with patients and their relatives and reviewed individual patient records. We also looked at the hospital's own performance data and records.

## Information about CircleReading

The hospital is registered to provide the following regulated activities:

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

During the inspection, we spoke with 16 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 6 patients and one relative.

The hospital was previously inspected in August 2016. At that time, we told the service that it must ensure that

# Summary of this inspection

statutory notifications are reported to the Care Quality Commission in a timely way and ensure that the Duty of Candour process is fully completed after an incident involving patient harm.

Activity (March 2018 to February 2019)

- In the reporting period March 2018 to February 2019 there were 8468 inpatient and day case episodes of care recorded at The Hospital; of these 61.5% were NHS-funded and 38.5% other funded.
- 15% of all NHS-funded patients and 28.6% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 74,748 outpatient total attendances in the reporting period; of these 49% were other funded and 51% were NHS-funded.

There were 126 doctors working at the hospital under practising privileges and a regular resident medical officer (RMO) worked on site at all times. There was a nominated accountable officer for controlled drugs.

**Track record on safety**

There was one incident that met the threshold for a never event. This was reported and acted upon when the provider became aware of it. A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.

There was a total of 452 clinical incidents reported in 2018 of which 34 (7.5%) were categorised as causing moderate harm, with the rest resulting in low or no harm.

There was one unexpected death reported in July 2018 and one serious injury reported during the reporting period.

There were no incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA).

There were no incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA).

There were no incidences of hospital acquired Clostridium difficile (C.difficile).

There were no incidences of hospital acquired E-Coli.

Circle Reading received 59 formal complaints between March 2018 and February 2019.

**Services provided at the hospital under service level agreement:**

- Provision of Sterile Services,
- Resident Medical Officer Provision,
- Pathology Services/Blood transfusion Services,
- Radiation Protection Services,
- Medical Records Archiving,
- Consultant Microbiologist Specialist Advice,
- Clinical Waste, Infectious Clinical Waste,
- Confidential Waste & Sanitary hygiene,
- Linen Services Contract,
- Courier Services,
- Paediatric Advisor Provision,
- Mobile CT/MRI Scanning Services,
- Histology & Cytology Services,
- Audio Typing,
- EBME,
- Clinical agency staff.

## What people who use the service say

People we spoke with were very positive about the care and treatment they received at CircleReading. Patients said they were very happy with the overall experience at the hospital.

# 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

We rated the safe domain as good.

There was generally good practice in all areas of the hospital.

There sufficient numbers of staff with the right qualifications, skills and experience to provide safe care and treatment to patients.

Staff knew how to protect vulnerable people from abuse and completed training in adult and child safeguarding.

Staff recognised and responded to deteriorations in the condition of patients. Comprehensive risk assessments for individual patients were completed and used to inform the care and treatment that was provided. There were suitable arrangements to ensure an appropriate response to emergency situations.

Patients were protected from the risks associated with hospital acquired infections. The majority of staff adhered to the provider's infection prevention and control policies.

The premises and equipment were fit for their intended purpose and well maintained. The premises were clean and in good repair. The environment was light, airy and spacious with comfortable furnishings.

There was sufficient equipment available for staff to carry out their roles efficiently and safely.

Medicines were generally well managed across the hospital. Controlled drugs were managed in accordance with the legislative framework.

Incidents were usually managed in line with the provider policy. There was a good reporting culture and staff felt confident to raise concerns. There was evidence of the provider making changes in response to feedback from staff and patients.

However,

Individual contemporaneous written healthcare records were not always sufficiently comprehensive or legible. In the outpatient department, some records made by medical staff were very difficult to read.

# Summary of this inspection

## Are services effective?

Good

We rated the effective domain as good. People had assessments of their needs, which include consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs.

Information about people's care and treatment, and their outcomes, was routinely collected and monitored. Outcomes for people who used services was positive, consistent and met expectations.

Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. The learning needs of staff were identified, and training was available to meet these learning needs.

Staff understood the need to obtain informed consent and were clear about what action they would take where a patient lacked capacity to make a decision.

## Are services caring?

Good

We rated the caring domain as good.

Feedback from people who used the service and those close to them was positive about the way staff treat people. People were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive. People felt supported and said staff care about them.

Staff spent time talking to people. They were communicated with and received information in a way that they could understand.

Staff responded compassionately when people needed help and supported them to meet their basic personal needs as and when required. Staff helped people and those close to them to cope emotionally with their care and treatment. People were supported to maintain their relationships with those close to them. They were enabled to manage their own health and care when they can, and to maintain independence

## Are services responsive?

Good

We rated the responsive domain as good.

Services were planned and delivered in a way that met the needs of the local population. Reasonable adjustments were made and action was taken to remove barriers when people find it hard to use or access services.

Facilities and premises were appropriate for the services being delivered. The premises were fully accessible to those with limited mobility and adapted seating as available throughout.

# Summary of this inspection

The appointments system was easy to use and supported people to make appointments. People were kept informed of any disruption to their care or treatment.

It was easy for people to complain or raise a concern and they were treated compassionately when they did so. Complaints and concerns were always taken seriously, responded to in a timely way and listened to. Improvements were made to the quality of care as a result of complaints and concerns.

## Are services well-led?

Good

We rated the well-led domain as good.

Leaders had a shared purpose and motivated staff to succeed. Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the desired culture.

There were high levels of staff satisfaction. Staff were proud of the organisation as a place to work and spoke highly of the culture. There were consistently high levels of constructive engagement with staff, including all equality groups. Staff at all levels were actively encouraged to raise concerns.

There were governance systems to ensure that risks were identified and acted upon. The provider and leaders at the hospital knew their service well and could provide a comprehensive narrative to support the data.

# Detailed findings from this inspection

## Mental Capacity Act and Deprivation of Liberty Safeguards

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

The hospital did not provide care or treatment for people with significant needs relating to their mental health but they did received training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) as part of their mandatory training.

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Surgery | Good | Good | Good | Good | Good | Good |
| Outpatients | Good | Not rated | Good | Good | Good | Good |
| Diagnostic imaging | Good | Not rated | Good | Good | Good | Good |
| Overall | Good | Good | Good | Good | Good | Good |

Good

# Surgery

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

## Information about the service

Surgery was the main activity of the hospital. Specialities treated included: orthopaedics, spinal, general surgery, gynaecology, ENT, refractive eye surgery and endoscopy.

### 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 provider had a statutory mandatory training policy which identified the training staff should complete within two weeks of their appointment to role. CircleReading staff were required to complete all mandatory training within eight weeks of their start date.
- CircleReading provided statistics about their overall compliance with the training expectation. At the end of March 2019 clinical staff were 85% compliant and non-clinical staff were 92% compliant with the policy. The surgical team were over 95% compliant with their training requirements. This exceeded the providers target completion rates.
- Training was delivered through a mixture of e-learning, classroom learning, and work-based competency assessments.
- Mandatory training included, equality and diversity, e–learning on PREVENT, MCA (Mental Capacity Act) and Deprivation of Liberty Safeguards (DoLS), challenging behaviour, cyber security awareness, protecting personal information, Dementia awareness, Disability awareness, Safeguarding adults, Basic life support, Safeguarding children and young people I, Intermediate life support, moving and handling part 2, and Advanced life support (clinical staff).
- All staff undertaking or assisting with endoscopic procedures must refer to Department of Health CFPP 01-06 guidelines. Circle staff were trained and assessed for competency in the procedure for decontamination of equipment following manufacturers' instructions. Staff told us automated endoscope decontamination is mandatory and manual disinfection is not permitted.
- The healthcare assistants undertook the care certificate standards 1 – 15.
- The hospital's resident medical officer (RMO) also completed mandatory training. For the completion of this training, the RMO received professional development points annually which they were able to use towards revalidation and appraisal.
- A designated member of staff, in the human resources team, collated training data to department leads monthly. A traffic light system was used to alert staff and managers if training was out-of-date or due to expire. The staff produce a certificate for the manager as confirmation that they have completed each element required.

- We reviewed the training status of the surgical team which showed that of 21 staff, there were three members of staff with an amber record and one member of staff that needed to complete a refresher for children's safeguarding.
- Staff we spoke with told us they had completed their mandatory training and they were given the time by managers to do so.

**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.**

- There was a hospital Safeguarding Children and Adult Policy and procedures document available to staff via the hospital intranet. The policy was issued in May 2018 and outlined clearly the process for staff to follow if they suspected a patient was subject to any form of abuse.
- There were safeguarding leads in each area who were trained to level 3 for children's safeguarding and a lead consultant surgeon as overall children's safeguarding lead.
- All registered nurses completed safeguarding level 2 for adults and children.
- Staff we spoke with in the surgical and theatre teams understood their roles in reporting and escalating any safeguarding concerns.
- Staff received an understanding of female genital mutilation (FGM) as part of their safeguarding training. Staff we spoke with could recognise abuse and understood how to report it.
- The manager told us that there had been no safeguarding issues reported on the ward during the last 12 months.

**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.**

- There was an up to date environmental cleaning and hygiene policy available to staff.
- Reliable systems were in place to prevent and protect people from a healthcare associated infection. Each area has a housekeeper who regularly monitored the standard of cleaning in the environment. All areas we visited were dust free and visibly clean.
- Senior staff peer reviewed each other's ward areas; environmental cleaning audits for the surgical wards and operating theatres were performed monthly. Results for the months of November 2018 to January 2019 were high with these areas overall achieving and average compliance of 97.5%.
- There was no incidence of methicillin-resistant staphylococcus aureus (MRSA) or methicillin sensitive staphylococcus aureus (MSSA), Escherichia coli (E-Coli) or Clostridium difficile (C. difficile) in the reporting period March 2018 to February 2019.
- In accordance with Department of Health guidance, all patients admitted to CircleReading premises for elective surgical procedures in high risk categories were screened for MRSA. This included orthopaedic surgery and all patients previously identified as MRSA colonised or infected. Other patients included those who resided in a care home, those who had been in an NHS hospital for longer than 24 hours in the previous year, and those with long term indwelling medical devices and a chronic wound which fails to heal. We saw evidence of the screening process in patient clinical records.
- We observed that all ward-based healthcare workers decontaminated their hands immediately before and after every contact or care. All staff we saw were bare below the elbow, in line with hospital policy. We saw staff washing their hands before and after patient contact, and after entering a dirty utility room in one clinical area. Staff we spoke with understood the importance of good hand hygiene.
- Hand gel was available at the reception desk in the day case area and throughout the premises. Personal protective equipment was available for staff in all clinical areas.
- Infection prevention and control (IPC) leads completed hand hygiene audits in all clinical areas on a monthly basis. Results showed that the surgical teams achieved

an average of 97.5% in the three months between November 2018 and January 2019. The service offered a hand hygiene training refresher once a year, using an ultraviolet light box.

- The staff could arrange for a deep clean of specific rooms or areas, when necessary. These were rarely required but the operations lead and the housekeeping lead assured us that they could ensure a quick and efficient response.
- Staff explained wound sites were checked regularly and neurovascular observations monitored when necessary, depending on the surgical procedure undertaken. Records confirmed this.
- The sterile instruments were brought into the theatre via one designated door and stored in a dedicated sterile store. The sterile trolleys were laid up in shared preparation rooms which were access controlled.
- Theatre instruments were sterilised off site, at the end of each case the dirty instruments and waste were bagged, labelled, sealed and removed from the theatre. The bags are collected in the general theatre corridor for removal.
- We saw theatre cleaning schedules were completed and signed daily in each theatre at the end of each day.
- Circle hospitals on two sites including Reading were participating in a 'Getting it Right First Time (GIRFT) surgical site infection survey. The survey included all diagnosed cases of surgical site infection on a selection of surgical sites which included hip, knee, shoulder, elbow and ankle replacement surgery 365 days prior to diagnosis, and abdominal hysterectomy 30 days prior to diagnosis.
- There were five operating theatres in use at the hospital. We found them to be visibly clean and tidy. Equipment had 'I am clean stickers'. However, we saw a table of attachments outside theatre 2 for minimal invasive surgery stack with no stickers.

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.**

- The day-case unit and inpatient wards were bright with almost double width corridors, well-lit with both natural and artificial warm lighting. There was minimal storage of equipment in the corridors so that it didn't cause obstructions or impact the patients' ability to walk around with or without staff support.
- The single en-suite rooms were neutrally decorated, with art work on the walls. All rooms had secure storage for patient possessions and clean, en-suite wet rooms. There was a sink in each of the rooms for staff hand-washing.
- There were large comfortable seats in the corridors with coffee tables with magazines and newspapers available for patients and visitors.
- In patient rooms there was a TV, seating, locked cabinets, and emergency oxygen and suction equipment. We saw that patients were allowed to personalise their rooms, in one patient's room there were flowers, photos, planned rehabilitation tasks on the wall along with motivational posters.
- There was a recreational room available to rehabilitation patients which included sports equipment, games and a television. There were snacks and hot and cold drinks available in the room with some dining tables. The room was well presented, visibly clean and provided a welcoming space for patients.
- Opposite the recreation room was a kitchenette usually used for patients to practice day to day activities during their recovery period following their surgery. The occupational therapist could assess patients' readiness for discharge.
- Two therapy rooms were available for patients to work with therapists on exercise regimes to improve movement and agility following surgery. This provided the staff and patients with the ideal space to support a speedy recovery.
- Room temperatures in the clinical rooms were monitored and checked daily to ensure the room was optimum for patient comfort.
- Resuscitation equipment was readily available. This equipment was stored securely, in tamper evident packs with serial numbered tags. The resuscitation equipment we looked at had been checked daily for the immediately accessible items on the top, with the full trolley checked weekly and a safety tag applied. All records were complete and up-to-date.

- Staff disposed of clinical waste safely according to the hospital policy. There was a service level agreement (SLA) with an external company for the disposal of clinical waste. We saw sharps bins were labelled, not overfilled, and signed for by staff in each of the surgical areas we visited. However, in theatre 2 the sharps bin was in use but not dated or signed.
- The service had a comprehensive, planned, preventative maintenance programme which was monitored for internal and external work required and for the timely completion of all work.
- As the hospital was still relatively new, there was only a fledgling equipment replacement programme. The service was in the very early stages of considering items that needed replacing in the not too distant future and theatre audio visual equipment were on the list.
- Equipment in the operating theatres had maintenance stickers with servicing due dates. For example, diathermy equipment, syringe pumps, and defibrillator units.
- Medical gas cylinders were stored in a dedicated room in containers fixed to the wall.
- We saw 'Stop before you block' and 'Radiation risk' signs in all necessary areas.
- In the anaesthetic room medical equipment checks should be completed twice daily. Checks included the anaesthetic machine function, the stock of controlled drugs, cleaning and refrigerator checks. We saw evidence that this was completed and documented in theatres three and four and information provided subsequent to the inspection visit demonstrated completion of checklists in theatre two.

**Assessing and responding to patient risk**

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

- Staff understood the need to record patient observations accurately. The hospital used the National Early Warning System (NEWS 2) scores to help identify deteriorating patients. The guidance and flow chart with actions to take were easily accessible and staff understood the triggers to escalate care to a doctor.
- There was a sepsis trolley available to staff, they understood the symptoms of sepsis and importance of monitoring patients through observations. The sepsis pathway was clearly understood, and staff knew when to escalate care.
- Staff were able to explain how they managed a patient who was vomiting. The patient's peri-operation record contained details of any anti-emetics already given, so staff could check what further medication could be given.
- Nursing staff told us that there was never any problem when escalating concerns to the resident medical officer, they were confident the response would always be quick.
- Patients arriving on the day-case ward were booked in at the reception desk; they were taken to a private room where they saw the consultant surgeon and the anaesthetist who was due to perform their operation. The consultant instructed the resident medical officer to arrange any outstanding investigations necessary before the procedure, to ensure there were no adverse issues.
- We saw staff completing the World Health Organisation (WHO) surgical checklist, this is a tool for the relevant clinical teams to improve the safety of surgery by reducing deaths and complications. All theatre staff were involved in the process.
- The staff at the hospital completed documentary audits of the WHO Safer Surgery checklist; Results for the previous 12 months were usually good with high levels of compliance. When there were areas of non-compliance staff developed action plans to ensure compliance improved.
- We saw evidence that staff undertook observational audit of the WHO process in the theatres. This provided ongoing assurance that theatre practice was in line with the national guidance. Action plans created following audits promoted continuous improvement in practice.
- Safety alerts were received by the hospital clinical governance team and circulated to staff via the hospital intranet. Those specific to the operating theatres were also displayed on the notice boards and cascaded at the Clinical Governance and Risk Management Committee Meeting.

- During our inspection we noted the order of the theatre list was sometimes changed at the team brief. We saw two examples where the pre-printed list was overwritten by the staff, which had potential for a transcription error. We were informed by the provider that this was in line with their standard operating procedures and was a process used whilst awaiting a commissioned upgrade to the computer-based system. No transcription errors occurred during the short period awaiting the upgrade, as the risks were recognised and mitigated in accordance with robust risk management and leadership.
- We saw the swabs needles and instruments were checked pre-operation and at the end of each procedure were recorded in the patient's operation record as per the WHO checks. Swab counts were also recorded on swab boards in the theatres.

**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 Head of Nursing and AHP's also deputised for the Hospital Director. The operational senior sister supervised the inpatient, day surgery and the theatre lead.
- The hospital shared staffing data which showed that the nursing and healthcare assistant (HCA) establishment had very few gaps. We saw there were four vacancies in the nursing and healthcare assistant requirements for the inpatient areas and between two and three vacancies in the theatre staffing establishment. The lead nurse told us that gaps in the shifts were almost always filled by bank staff.
- Lead nurses told us that rotas are prepared a month in advance and the service uses a computer programme to match the nursing requirements with the patient bed planner. The leads for each area checked the system on a weekly basis to flex staffing to reflect any changes.
- On the day of our inspection, the board in the day case area showed that there were four registered nurses (RNs) and two HCAs covered the early shift with three RNs and two HCAs for the afternoon shift. This staffing compliment looked after 15 patients.
- Nursing and healthcare assistant staff work a variety of shifts with some working long days (6.45am to 9.30pm) others work conventional early shifts (6:45am to 2:45pm) and late shifts (12:00pm to 8:30pm). The night staff work between 8:00pm and 7:30am which allows for a handover in the morning.
- Nursing staff told us that there were no staffing concerns, even when someone called in sick, as managers secured cover in good time.
- In the operating theatres there were three vacancies at the time of our inspection. The manager told us that two posts had already been filled and the recruits were starting in the near future.
- Gaps in the staffing model for the operating theatres were usually filled by agency staff as there were no suitably qualified staff on the bank. The service followed the 'Staffing for Theatres' guidelines produced by the Association for Perioperative Practice.
- Agency staff were employed to ensure there were safe staffing levels. The service provided an induction pack and an 'anaesthetic booklet' which contained a plan of each of the rooms showing what equipment could be found and where. What medicines available and where they were stored.
- Emergency cover for the operating theatres was provided by four on-call staff each night and at weekends. Staff told us that they were rarely called in.

**Medical staffing**

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

- The resident medical officer worked a week on-week off shift pattern; there was a formal handover process between resident medical officers. If they were required to work during the night the service employed locum cover for the next day, covering 24 hours.

- The service ensured that a consultant surgeon was always contactable 24hrs a day and within a 30 minutes travel time, if required to attend a patient. Each consultant was responsible for making suitable cover arrangements should they not be available during the time they have patients being treated under their care.
- A consultant rota was available to staff which indicated which consultant should be contacted if required.
- Anaesthetists were contracted for all operating sessions and there was an on-call rota out of hours and at weekends, should staff have any concerns, or if a patient needed to return to theatre.

**Records**

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

- Patient records were created and maintained in paper form throughout the service. In the surgical areas these were stored securely in lockable trolleys at the nurses' station.
- Records contained standardised pathways such as total hip replacement or total knee replacement. Pre-operative and post-operative records were integrated into a continuous record.
- Records we reviewed in the surgical areas were complete and up-to-date.

**Medicines**

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

- The hospital introduced a Medicines Management Policy in June 2012 which was reviewed regularly, most recently in June 2019. The policy described the steps to be taken to ensure the safe and secure management of medical records, and the responsibilities of all CircleReading employees.
- Each inpatient had a lockable drawer in their room for their own medicines. Pharmacy staff checked the patients' medicines on a daily basis.
- Pre-operation records include the patients' weight and body mass index (BMI). This enabled staff to prescribe medicines tailored to the patients' requirement.
- Staff checked and recorded the refrigerator temperature daily in the inpatient ward clinical room. We saw insulin stored properly at the required temperature.
- The service had an escalation process clearly displayed for staff to follow if the fridge temperature was outside the expected range.
- Registered nurses checked the controlled drugs stock as part of the morning and evening handover.
- In the day-case area the medicines were stored in a lockable cupboard in the clinic room which was only accessible to authorised staff. The controlled drugs were locked within a locked cupboard.
- In the operating theatres we saw that controlled drugs were checked twice daily by two practitioners. The recovery room temperatures were also monitored and recorded daily.
- The resuscitation trolleys included an anaphylaxis kit and there was a difficult airway trolley, all checked and signed weekly.

**Incidents**

**The service had a system for reporting and managing patient safety incidents. Staff recognised and reported incidents. Managers investigated incidents and shared lessons learned with the whole team and the wider service.**

- There was one never event that occurred during the reporting period. Appropriate investigation and notification took place in a timely way, once the provider was made aware.
- A near miss also occurred but this was prevented because the provider had systems in to identify an incorrect surgical site and prevent the procedure continuing. This demonstrated a positive reporting culture and staff who felt supported and confident to speak out when something was not right.
- The near miss was reported, and a root cause analysis of the event was completed. The learning from this investigation was shared with the theatre team and 'Stop before you block' was introduced.

Good

# Surgery

- One staff member gave us an example of receiving feedback following an incident in theatre when a patient had a cardiac arrest. Staff were quite shaken by the incident; the head of nursing attended the subsequent debrief and ensured that the staff were updated with the patient's condition. The patient recovered well, and the staff have received several updates from the local NHS hospital where the patient was transferred.
- Information provided as part of our inspection showed that, in general, staff reporting had increased, year on year, with a high proportion no harm events. This indicated an improved picture of incident managing and reporting.

## Are surgery services effective?

Good

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

**Evidence-based care and treatment**

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

- People had their needs assessed, and their care planned and delivered in line with evidence-based guidance, standards, and best practice. The service ensured that care was managed in accordance with The National Institute for Health and Care Excellence (NICE) guidelines, for example we saw evidence of care pathways which were aligned with NICE guidance in each set of patient notes.
- Staff used care plans to record all assessments and care given whilst patients were in their care. The care plan included the pre-operation assessments and the operation notes and recovery care. This meant that the staff were able to see all the necessary information they needed in one place.
- The operating theatre senior team used audit to involve all staff groups in quality improvement of practice. The Association for Perioperative Practice and NICE guidelines were used throughout the service and there was evidence of publications in professional journals by the anaesthetic leads.
- The anaesthetic leads in pain management cascaded information about advances and changes to pain management to all staff and the surgeons contributed to the breast registry and to the National Joint Registry.

**Nutrition and hydration**

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

- Patients admitted for surgical procedures were not emergency cases and therefore elective and fit enough for the procedure. They were screened prior to admission to ensure they were not too frail, dehydrated or nutritionally compromised. Patients did not remain on the surgical wards for more than three or four days.
- We saw fluid balance charts documented oral and intravenous fluids given to patients, along with nutritional assessments carried out for each patient. Staff demonstrated a good understanding of the importance of assessing nutrition and hydration needs.
- Patients were always encouraged to drink sufficiently. The chef was sometimes asked to discuss patients' food choices if patients requested particular dietary items.
- Patients who were 'nil by mouth' told us they were allowed to sip water during the few hours before their operation. The provider fasting policy was in line with national guidance.

**Pain relief**

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

- Staff used a numerical assessment tool measure patients' pain. Patient records showed that analgesia and antiemetic drugs were prescribed and administered when necessary.
- Patients told us their pain had been managed effectively by the staff and they had no complaints.

**Patient outcomes**

Good

# Surgery

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

- Patients' progress following orthopaedic surgery was monitored using the UK specialist Rehabilitation Outcomes Collaborative (UK ROC) tools. UK ROC was set up through a Department of Health Research Programme Grant to develop a national database for collating information to be used to improve inpatient rehabilitation.
- Circle Hospital (Reading) surgeons also used individual outcome measures following some procedures to evaluate the progress of their patients.
- The hospital collected patient reported outcome measures (PROMs) data for all NHS patients receiving full hip or knee replacements, for the NHS England data base. This was published on a monthly basis.

**Competent staff**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. 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 we spoke with were very positive about the appraisal process. They told us it was relevant to their needs and they could take the opportunity to discuss their development and ensured they maintained a high standard of clinical practice.
- A new staff member described the induction they received and found it very helpful and better than they had received in previous posts. The vision and strategic objectives of the hospital were explained, and it helped to focus on what they needed to aim for to provide the highest quality care.
- Following their induction, staff were supernumerary for two weeks before working fully in their roles.
- Competency based training was available for theatre staff in recovery, scrub and anaesthetics. Equipment training was usually provided by the suppliers to a small group and then cascaded to the rest of the team.
- All the theatre staff we spoke with said they had received an appraisal within the year and all found them beneficial.
- Staff told us there was plenty of in-house training available; all the team had recently participated in ILS training (Immediate Life Support). Two staff members had recently completed surgical assistant training at university.

**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 good communication between staff when handing over patients following an operation and returning to the ward.
- The whole team including representatives from the medical, allied health professions and nursing staff met on the first Monday of each month for an update on any concerns about care or procedures.
- There was a meeting first thing every morning for the leaders from each area to assess the bed capacity and any changes to admissions for the day; this included a best interest discussion. Information was cascaded to the frontline staff at the 8.30am huddle or at handovers.
- There was a regular multidisciplinary (MDT) meeting each Tuesday. These meetings included the nursing and medical staff along with the physiotherapist, occupational therapist, speech and language therapist representatives. The purpose was to discuss the progress, review the goal setting for each patient, and plan for their discharge.
- We attended an MDT meeting during our inspection. We observed good interaction between different professional groups, discussion was open, and everyone was able to contribute.
- Staff told us that they felt team communication was effective as there were multiple opportunities for sharing knowledge. MDT minutes were always typed and available to staff.
- As well as the MDT meetings there were twice weekly ward rounds which included the consultant in charge and the RMO.

Good

# Surgery

**Seven-day services**

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

- Nursing care was available seven days a week 24 hours a day, with a resident medical officer on site for the same hours.
- Five operating theatres were open and available between 8am and 8pm Monday to Friday and 8am to 4pm on Saturdays. The endoscopy suite was open from 8am to 6pm Monday to Friday.
- Consultant surgeons were on call seven days a week 24 hours a day when there were patients on the wards under their care.
- The surgical teams were supported by a pharmacy service available Monday to Friday with some access to an on-call service outside of those hours.

**Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)**

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

- One patient explained that they had attended a few days before the operation for a pre-assessment appointment. They told us that they had received a full explanation of the operation they were going to have, and their spouse was able to ask questions and have any fears allayed too. This meant they were fully informed before they gave their consent to the planned operation.
- Staff explained that the hospital did not admit patients with severe mental illness, as the hospital was not able to meet their needs related to this. The initial screening process allowed these patients to be referred to more appropriate provision.
- Staff received training in the Mental Capacity Act and DoLS as part of their mandatory training and understood that any consideration for the patient's capacity to consent related to a specific, individual decision. The knew how to act if a patient became confused, for example.
- Formal written consent was recorded pre-operatively in all the patient records that we reviewed.

## 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.**

- A patient described staff as, "Brilliant, they were responsive to calls and particularly good at managing my pain". One said, "The fact that I'm able to speak to you pain free is marvellous and shows what excellent care I've had". Another said, "The nurses, doctors and physiotherapists were all attentive to detail and gave the best care I've had so far, there are no negative concerns at all".
- Patients who we spoke with were happy to recommend the hospital for their care; they described staff as professional and knowledgeable. One said, "The physiotherapists were excellent the team was perfect, I have no complaints at all".
- We saw good examples of staff respecting the patients' privacy and dignity in the operating theatre areas. Staff kept patients covered for as long as possible prior to the surgery. Curtains were kept around the patients in the recovery room when personal care was being delivered.

**Emotional support**

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

- Nurses were attentive. One patient said, "They monitored me regularly, and gave me updates so that I knew what was happening. That reassured me that all was well".
- We saw staff having supportive reassuring conversations with patients in the anaesthetic rooms.

**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.**

Good

# Surgery

- We found there were some concerns expressed by a small number of patients that they did not have enough involvement in their goal setting; this was reflected in some patient feedback cards. The staff developed actions to address this and produced some visual aids to keep in patients' rooms which focused the patients and served as a reminder. The staff also ensured goals were discussed and agreed with the patient.
- We observed a medicines administration round; the nurse introduced herself, explained her purpose in the room. She went on to explain to the patients what the medicines she was administering were for and the possible side effects the patient may have.

## 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.**

- The facilities and premises were appropriate for the clinical services that were planned and delivered.
- There was a day surgery unit that consisted of 20 pods, which enabled patients to have minor procedures or surgery, without having a planned overnight stay in hospital.
- The hospital used a criteria assessment list to ensure they would not be treating patients who were not suitable to be cared for at the hospital. Patients excluded from care at the hospital included; patients under age 18, patients with incapacitating disease that is a constant threat to life, patients with a BMI greater than 50, patients with an unstable psychiatric disorder on active treatment, and patients with suspected cancers treated under the two-week wait rule, who should go through the local NHS pathway.

**Meeting people's individual needs.**

**The service was selective but for the patients' that met the acceptance criteria their individual needs and preferences were considered. Staff made reasonable adjustments to help patients access services.**

- The service did not accept patients for treatment who had complex needs. One member of staff explained there was always potential for any patient to have a mental health crisis whilst under their care, and they went on to explain how the staff would manage such an event.
- We were given an example of an occasion when a patient had such a mental health concern and wanted to harm themselves. The nursing staff immediately informed the nurse in charge and the unit manager, who contacted the consultant psychologist, as set out in the hospital policy. The psychologist responded quickly, and a plan was implemented to protect the patient until they could be transferred to a more suitable environment, though in this case that was not necessary.
- The provider had a Dementia Strategy which advised staff caring for patients living with dementia. The Mandatory Training Policy demonstrated that this included dementia awareness training for all staff. Staff were occasionally made aware of such a patient booked to attend for surgery; in these circumstances the patient was usually accompanied by a carer.
- There were no special menus for patients with different nutritional requirements, but we were told that the chef would always do their best to accommodate patient choices.
- The staff had access to a telephone interpreting service and the provider told us that this was used. However, some staff told us that they relied on other staff as interpreters, if they were caring for patients whose first language was not English.
- Information was provided to patients before admission including hospital maps and directions, the consultant's name and details of any tests or procedures. However, information seen on the day of the inspection was only available in English. The provider has assured us that information is readily available in other languages, if necessary.

- All in-patients had their own rooms with en-suite bathrooms. The rooms had walk in showers with a shower seat for use when patients were less able to stand. There were no obvious trip hazards.
- The building was fully accessible for people with limited mobility. Corridors and doors were spacious to allow easy transit for wheelchairs. External doors were automated to ensure people could gain entry to the reception area.

**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.**

- In the reporting period March 2018 to February 2019 the hospital had cancelled five procedures for a non-clinical reason. Four of those five patients were offered another appointment within 28 days of the cancelled appointment.
- Patient waiting times were monitored through 18-week referral-to-treatment (RTT) waiting time guidelines provided by the Department of Health. Patient pathways were reviewed on a monthly basis within the administration department. The consultant secretaries monitored the list closely and patients reaching their RTT date would be noted and escalated to the consultant for review.
- Service capacity was reviewed on a weekly basis by the hospital's leadership team. Any notable reduction in capacity is highlighted and escalated within the administration team to prevent an extended wait or inconvenience to service users.
- The hospital data for 18-week RTT for the three months of December 2018 and January and February 2019 showed that over 94% of patients received their procedure within 18 weeks.

**Learning from complaints and concerns**

**It was easy for people to give feedback and raise concerns about care received. The service investigated reports and shared lessons learned with all staff**.

- We saw leaflets displayed for patients informing them how to make a compliment, comment, concern or complaint.
- Complaints data provided by the hospital showed a log of 32 complaints received for the hospital between September 2018 and February 2019. The log included lessons learned, and actions the service took to address the concerns expressed in each complaint.
- The information provided by the hospital showed that patients should expect to receive a response to their complaint within 20 working days. The range of responses in days was between 10 and 120 days. The average time taken (not including the one that took 120 days) was 48 days; 56% of the complainants were from NHS patients.

## Are surgery services well-led?

Good

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

**Leadership**

**Leaders had the integrity, skills and abilities to run the service. They were visible and approachable in the service for patients and staff.**

- Ward staff told us that the hospital leaders and managers were visible and supportive and hands on when required. 'The ward manager is approachable, helpful and supportive'. There was no anxiety about raising a concern, if needed.
- Operating theatre staff told us that the senior management team were always available, and they felt involved in discussions about revenue, governance and quality. The staff also told us the theatre manager worked clinically and would fill gaps in the shifts when required.
- There was a process in place to monitor consultants practicing privileges, and we saw that one consultant had been temporarily suspended in October 2018 because they did not produce their relevant annual appraisal information. The suspension was lifted when the appropriate appraisal evidence was submitted.

**Vision and strategy**

Good

# Surgery

**The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff understood and knew how to apply them and monitor progress.**

- The hospital vision was to build a great hospital dedicated to the patients, with a strategy to deliver outstanding clinical outcomes. Staff were very much aware of the hospital strategy and vision and they knew their own role in achieving service objectives.
- There were posters throughout the service regarding the Circle 'Credo', which was the overall provider statement. We were told the hospitals vision and values were designed by the staff at an away day.
- The Circle Operating System (COS) The Circle Way was a values-based system which captured the provider values and was displayed around the hospital. It focused on empowering professionals and engaging staff in a partnership with leaders in the pursuit of high-quality service delivery and patient experience, with safety a key feature.

**Culture**

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

- Staff told us that there was an open culture at the hospital and the teams were 'great to work with'. 'The hospital is small, so everyone knows each other' and 'Teamwork is great as everyone is approachable'.
- Staff in all areas talked to us about the hospital being the best place they had ever worked and how well supported they felt. They talked about pride in their work and wanting to provide good care.
- Operating theatre staff said there was a good culture with confident staff who were prepared to challenge others if they were concerned about anything. The hospital had appointed champions who promoted safety and speaking up to escalate concerns.
- The staff in the operating theatres told us of their involvement in the business case around purchasing equipment. Current assets were still serviceable but discussions around replacing expensive equipment and the capital investment involved the whole team contribution.
- The senior staff in the operating theatre department told us they were proud of how their team responded to change and how they have gained the confidence to challenge poor practice and suggest new ideas for improvement. They told us the whole team was fully on board with audit of the WHO checklist and supportive of the new first assistant training.
- Service leaders told us that e learning training included the duty of candour and managers revisited this at the 'patient hour' discussions with teams.

**Governance**

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

- The hospital had a governance and assurance framework to ensure that regulatory standards and elements of governance were brought together and reported on; and to provide assurance to the Circle PLC board and its audit and risk committee.
- In order to deliver 'Quality without Compromise' the hospital had monthly Clinical Governance and Risk Management Committee Meeting attended by the senior team and the department and service leads.
- There was a governance structure and process in place within the surgery division. Governance meetings took place on a monthly basis and also reported on finance, performance and quality issues within the division. They looked at incidents such as the hospital's acquired infection reports and compliance with hand hygiene audits. These meetings were recorded, and the minutes were shared with staff.
- The governance meetings included a Clinical Chair, the Registered Manager, Head of Nursing and Allied Health Professionals and members of the senior management team. This multidisciplinary structure promoted a focus on good quality care and clear lines of accountability.

- All staff had a range of standard operating procedures (SOPs) available to them, accessible on the intranet. The documents we saw were within their review date.
- There was a programme of audit; those we saw were carried out regularly. There were audits for infection control and prevention, environmental audits as well as audit of compliance with the preoperative checks in the WHO Five Steps to Safer Surgery checklist and VTE assessment. However, there were no observational audits of compliance with the WHO checklist.

**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 hospital maintained a register of risks which were graded high to low. Control measures were reviewed and discussed at the monthly meeting. The register included the ageing endoscopy washers and the lack of an electronic or robust solution for tracking patient pathways.
- Complaint themes and key areas of learning were shared and reviewed at the monthly Clinical Governance and Risk Management Committee and disseminated to all departmental leads for shared learning.
- Staff told us about 'Stop the Line'; a process which they followed if there was a serious concern which required a pause in activity. This would initiate a 'swarm' which brought together the senior staff quickly to assess the situation for risk and resolve the issue before proceeding with the procedure or activity.
- The executive board meeting took place monthly; members used a dashboard of metrics as a means of ensuring that they had oversight of service performance and compliance with standards. The dashboard consisted of 93 metrics which included, for example, compliance in environmental hygiene, infections, waste management, incident reporting, complaints, patient feedback, information governance, accreditation, compliance with NICE guidance, safety thermometer measures, and audit of practice.
- The executive board meeting agenda included a finance report and development plan and an administration review, as well as the detail within the dashboard.

**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 service employed an information governance and compliance lead, supported by a quality and assurance team. The Director of Nursing was the Caldicott Guardian for the hospital.
- Dashboards were used effectively to monitor and improve quality and performance. Data collection included incidents, complaints, information governance breaches and medication error.

**Engagement**

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

- Staff described patient feedback as 'excellent'; they felt this was because patients were respected and listened to. Patients had choices about the food they wanted to eat, and their pain was regularly assessed and addressed.
- All patients were given a feedback card with their discharge letter and staff encouraged them to complete the card and return it to the staff.
- Staff in the operating theatres told us they received information relating to best practice and professional development opportunities via email, staff meetings, the notice boards and the 'Hot Topics' publications.
- The staff had the opportunity to complete a satisfaction survey annually.

Good

# Outpatients

| | |
|---|---|
| Safe | Good |
| Effective | Not sufficient evidence to rate |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |

## Information about the service

Outpatient services available at CircleReading included ear, nose and throat (ENT), audiology, gynaecology, orthopaedics, cardiology, plastic surgery, ophthalmology, gastroenterology, phlebotomy, rheumatology, urology and physiotherapy.

Patients could access the service either through a referral from their general practitioner (GP) or they could self-refer. The service accepted patients who had private medical insurance, self-funded and NHS patients through the NHS Choose and Book Service. The service did not provide a children and young people's service.

The service opened between 8am and 8pm Monday to Friday, and between 8am and 4pm on Saturdays. There were 15 outpatient consultation rooms, four treatment rooms, a minor operations room and a physiotherapy unit.

There was also a satellite outpatient service in Nettlebed, which consisted of a rented room within a GP surgery. This clinic ran every Tuesday, the opening hours were dependent on demand. Services available were limited to consultations for orthopaedics and gynaecology.

There were 10 nurses, four healthcare assistants and two administrative staff employed for the outpatient service. 126 consultants also worked under practising privilege contracts.

Between March 2018 and February 2019 there was on average 4500 attendances to the outpatient department per month. From this figure the number of NHS and privately funded patients were similar.

During our inspection, we visited all outpatient department areas at CircleReading hospital; however, we did not visit the satellite clinic service. We spoke with 14 members of staff and nine patients. We reviewed 10 patient's healthcare records and numerous service records.

### Are outpatients services safe?

Good

At this inspection, the safe rating has remained the same as **good**

**Mandatory training**

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

- For the outpatient department, 93% of staff were up-to-date with mandatory training. This included medical, nursing, allied health professionals and administrative staff. The hospital set a target of 90% for eLearning and 85% for face-to face training compliance.
- Mandatory training was delivered through a combination of e-learning and face-to-face sessions. Training included: basic life support, dementia awareness, disability awareness, document and record keeping, safeguarding adults and children, manual handling and fire awareness.

- A training matrix was held by the human resource (HR) department. A red, amber, green rated system was used for the matrix, which allowed easy identification of staffs' individual training requirements and compliance.
- Managers said HR staff contacted them when staff training was due, which they then booked for staff. They said this system worked well.
- Staff told us that mandatory training was effective and that they were booked onto training well in advance of their previous training expiring.

**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.**

- For the outpatient department, 93% of staff had completed mandatory safeguarding adults and children training. This figure includes medical, nursing, allied health professionals (AHPs) and administrative staff. Non-clinical staff completed level one and clinical staff level two safeguarding training for adults and children.
- Staff knew what constituted a safeguarding concern, how to recognise different types of abuse and how to manage a safeguarding incident in line with the hospital's procedure.
- Staff could identify the dedicated safeguarding lead within the hospital. This was the head of nursing and AHPs. They had completed level four adult and children's safeguarding training, along with three other senior hospital managers.
- Between June 2018 and June 2019, there were no safeguarding incidents raised within the outpatient department.
- Staff showed us they could access the hospital Safeguarding Children and Adult Policy through the staff intranet. This policy was in date and outlined the process staff should follow to manage a safeguarding concern. It was reflective of legislation and publications such as The Care Act (2015) and the Department of Education's (2015) Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children. The policy also provided information on female genital mutilation.
- We saw a range of up-to-date safeguarding information on the intranet, including relevant local authority safeguarding contact details and links to national best-practice guidance.
- Staff in the outpatient department had undergone suitable pre-employment checks. This included disclosure and barring clearance. Managers told us that only those authorised and cleared to work at the hospital did so.

**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.**

- All hospital infection control and prevention policies were in date. This included policies for hand hygiene, antimicrobial and aseptic non-touch technique policy. Staff could access these through the intranet.
- All staff had completed yearly infection control and prevention training. This included medical, nursing, allied health professionals and administrative staff.
- We saw that staff decontaminated their hands regularly in line with the, "My 5 Moments for Hand Hygiene" by the World Health Organisation. Hand cleaning notices were displayed throughout the department reminding staff and visitors to clean their hands. There were suitable hand-washing facilities in each clinical area.
- Hand hygiene audits were carried out monthly by a healthcare assistant who had completed additional training for this role. Audit results from April and May 2019 showed 100% compliance against set measures.
- Staff had access to personal protective equipment, such as gloves and aprons, which we saw staff use appropriately.
- All areas of the outpatient department were visibly clean, well-organised and free from clutter. Furnishings such as seating were made of wipe-able materials.

- Nursing staff cleaned equipment and applied an 'I am clean' sticker to equipment to show it was clean and ready to use.
- Dedicated cleaning staff were employed for the department. They carried out a thorough clean of all areas at the end of each working day. We saw that cleaning schedules were followed, with up-to-date cleaning logs kept.
- Staff said that precautions were taken when seeing people with suspected communicable disease such as infectious diarrhoea. They followed isolation procedures and ensured that any area used was deep cleaned afterwards.
- Five members of staff carried out nasoendoscope (cameras passed in to the nose for examination) decontamination and records showed they had received specialist training for this role. An up-to-date log was kept showing this equipment had been decontaminated.
- Staff were familiar with the hospital's decontamination of re-usable medical devices policy. This policy was in date with version control, and through discussion staff demonstrated they followed the procedures within it.

**Environment and equipment**

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

- At our last inspection in 2016 we raised concerns that the adult resuscitation trolley contained a mixture of adult and child resuscitation equipment. At this inspection, we found the adult resuscitation trolley contained only adult resuscitation equipment.
- All clinical staff were trained to complete basic life support for children. Staff said in the event of child requiring resuscitation they would perform basic life support and call for an ambulance.
- Resuscitation equipment was readily available and checked daily. The resuscitation trolley was fastened with a tamper proof seal and staff completed a thorough check of the equipment weekly.
- Patient blood samples were kept in a blood fridge in one clinical room whilst staff were awaiting courier collection. However, we saw this fridge and the door to the clinic room were unlocked; the room was regularly used by staff to see patients throughout our inspection.
- The hospital standard operating procedure (SOP) for the collection and transportation of pathology samples version two was not up-to-date as the review date of August 2018 had passed. This policy did not determine whether the fridge or the door to the clinic room was meant to be locked.
- We raised our concern to managers about the blood samples not being kept safely. They took immediate action to secure the room and confirmed that the SOP would be reviewed. After our inspection the provider told us that a door access key lock had also been installed for the room.
- Staff told us that the service had enough suitable equipment to help them safely care for patients.
- Servicing and electrical safety testing records showed all equipment in the outpatient department had received necessary servicing and maintenance.
- Staff disposed of clinical waste safely in line with hospital procedures. This included using coloured bin bags and bins appropriately depending on waste type.
- Sharps bins throughout the department were correctly assembled, labelled and were not over-filled. This reduced the risk of staff and visitors sustaining a needle stick injury.
- There was service level agreement in place with an external company for the disposal of clinical waste.
- The treatment room where minor procedures were carried out had an air filtration system in use.
- The outpatient area was welcoming and comfortable for people who were waiting to be seen.

**Assessing and responding to patient risk**

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

- Environmental risk assessments were regularly carried out in the department, by nursing staff who had received additional training. This included Control of Substances Hazardous to Health (COSHH), trips and falls and medical gases.

Good

# Outpatients

- Standardised risk assessments were carried out and completed in patient healthcare records, before patients were admitted for a procedure at the hospital. Risk assessments included, but were not limited to falls, pressure area care, infection, nutrition and moving and handling.
- Patient risk assessments were in line with national guidance. For example, we saw that The National Institute of Health and Care Excellence guideline [NG89] Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism was reflected in the risk assessment for venous thromboembolism.
- Staff knew how to deal with any specific risk issues. Standardised and correlating risk management plans were in patient's healthcare records and these showed that identified risk was managed positively. For example, one patient's risk assessment showed they lived with diet-controlled diabetes. An appropriate care plan was in place ready for the patient's admission.
- The service did not use the World Health Organisation (WHO) Five Steps to Safer Surgery checklist for minor procedures carried out in outpatients. This meant the service was not following best practice guidance. Since the inspection the provider has ensured that the safety checklist is now used.
- Staff said they would respond promptly to any sudden deterioration in a patient's health, medical emergencies or challenging behaviour. They told us that they were able to seek support from senior staff in these situations and all worked together.
- The service had access to specialist mental health support externally if staff were concerned about a patient's mental health. Doctors could also refer patients to the psychiatrist who provided regular clinics in the department.
- The hospital had a referral eligibility criterion. A referral to the hospital would be rejected if a patient lived with an "unstable psychiatric disorder and [was] receiving psychiatric treatment".
- Staff asked patient's about their mental health needs during pre-assessment clinic. They shared any information of concern with the lead consultant and anaesthetist for review.
- Illuminated warning signs were in place reminding staff and visitors not to enter specific rooms where laser treatment was being used.
- The hospital had a procedure called, "Stop the line" which staff could instigate when there was a serious risk to patients. This led to a prompt senior management meeting. For example, staff said this had recently been activated due to staff having an issue accessing the electronic imaging system. Staff said this led to an immediate senior management meeting with necessary action taken to resolve the issue. They told us that this procedure was effective.
- All invasive procedures in outpatient department were carried out by consultants under their practicing privileges. Records showed that all nursing staff assisting with invasive procedures were compliant with mandatory infection control and hand hygiene training. Staff assisting with minor procedures had also completed relevant competencies to support this role.

**Nurse staffing**

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

- There were 8.1 whole time equivalent (WTE) registered nurses employed for the outpatient department.
- Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift. Staffing rotas were planned monthly.
- The service had a low vacancy rate. At the time of inspection there was one WTE healthcare assistant post vacant which was out to advert.
- There was one WTE administrative position for the outpatient department, with support from other administrative staff from alternative areas as required.

- Physiotherapists were not directly employed within the outpatient department.
- Planned daily nursing numbers for the outpatient department were two managers, seven registered nurses and four healthcare assistants. Staff said that nursing numbers and skill mix was good.
- Managers could adjust staffing levels daily according to the demands of the service. Staffing numbers were increased by using internal bank staff or by existing staff working overtime.
- Staffing records confirmed agency nursing staff were not used in the outpatient department.
- The nursing staffing rota from 1 June 2019 to 24 June 2019 showed the number of nurses and healthcare assistants on all shifts matched the planned numbers.
- Sickness rates for nursing staff were 6% from June 2018 to June 2019.
- Turnover rates for nursing staff were 27.2% from June 2018 to June 2019.
- Managers used internal bank staff who were familiar with the service. They made sure that all bank and agency staff had a full induction and understood the service. Records showed that bank staff were used rarely. For example, in June 2019 no bank staff had been used.
- Nursing handover took place between the morning and afternoon shift. We saw that managers used this time to disseminate important information to staff.

**Medical staffing**

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

- The hospital employed 126 consultants, working under practising privileges.
- Locum and agency medical staff were not used.
- The hospital had a resident medical officer (RMO) available 24 hours a day, seven days-a-week. This ensured there was always access to a doctor outside of the outpatient department opening times in an emergency. The RMO rota for June 2019 confirmed this.
- Speciality clinics were arranged for the days that relevant consultants were available.
- Medical Advisory Function (MAF) meetings took place monthly. The Clinical Chair and hospital director attended these with speciality input as required. Meeting minutes from January and February 2019 showed that medical matters were reviewed. For example, new practising privilege applications were reviewed and either granted or declined. There was evidence in these meeting minutes that following review, one consultant was appointed and another who was deemed not safe to practice and therefore declined.

**Records**

**Staff did not always keep detailed records of patients' care and treatment. Important information was missing. However, records were stored securely and easily available to all staff providing care.**

- All patient healthcare records used by nursing, medical and allied healthcare professionals were in paper format. The department also used an electronic system for appointment bookings, blood and imaging test results.
- We reviewed ten patient's healthcare records. In five of these records the entries by medical staff were very difficult to read. Entries by some medical staff were also incomplete, with dates, time of consultation and the consultant's name was missing. We raised our concerns with a manager who confirmed our findings and said they would look into this further.
- Each month the healthcare records of ten patients, who had been admitted for care and treatment were reviewed. This was completed by nursing staff and included review of outpatient pre-assessment records. The audit looked at whether staff entries, patient demographics, consent and procedure records were complete. Audit results from May and June 2019 showed good compliance with record keeping overall.

- However, there was not sufficient review of outpatient healthcare records since this review was limited to pre-assessment records only. There were no other patient healthcare records audits.
- Records were stored securely in locked cabinets, which prevented unauthorised access.
- Staff were able to access patient records easily through the hospital's record library system. There was also a system for ensuring that medical records were available for clinics. Administrative staff collected patient healthcare records the day before the clinic and stored them in locked cabinets in the outpatient department. Nursing staff at the start of the shift then checked these were all present and correct, taking them to the appropriate room for the consultant.
- At the end of each clinic nursing staff collected clinic notes and these were then checked back in electronically, to the hospital record storage facility.
- Approved staff had access to the hospital's blood and imaging results system. Nursing staff accessed and printed necessary blood results ready for consultations.
- All staff were up-to-date with mandatory record-keeping training.
- The hospital communicated with GPs following each patient consultation. Medical secretaries typed dictated consultant letters and sent these to the patient and GP. Staff said that these letters were sent promptly within a couple of days.

- There was a medical records policy which was in date with version control. Staff could access this through the intranet.

**Medicines**

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

- Medicines were stored and managed safely in line with the hospital's medicine policy. Medicines were stored in locked cupboards in a dedicated medicine room which was locked. The lead nurse on duty held the keys to the medicine cupboard.
- Certain medicines were stored in a medicine's fridge. This fridge was at the correct temperature when we checked. Records for June 2019 showed the fridge temperature was checked daily with readings within normal limits. There was a protocol for staff to follow if the temperature was outside of the set range.
- There was a medicines management policy which was in date and version controlled. This was accessible to staff through the intranet.
- We randomly checked stock medicines and found they were in date and stored according to manufacturer recommendations. The outpatient department did not hold any controlled drugs.
- The hospital's pharmacy service was located within the outpatient department. The pharmacy team were responsible for the ordering and the supply of stock medicines.
- Managers said the pharmacy team carried out monthly checks of stock medicines to ensure appropriate quantities of medicine were ordered and that medicine expiry dates were reviewed.
- Suitable safety checks were in place prior to patients receiving their medicines. Pharmacy staff carried out these checks and also provided specific advice to patients and carers about any medicines dispensed.
- Nursing staff demonstrated through discussion with the inspection team that they followed current national practice when prescribing, administering, recording and storing medicines.
- A manager explained the process to ensure staff knew about safety alerts and incidents relating to medicines. They said that medicines safety information would be disseminated from the monthly Clinical Governance and Risk Management Committee Meeting. We checked the minutes from these meetings for February and March 2019, which showed medicines management was a standing agenda and discussed.
- Medical gases were stored safely in line with the hospital medical gas policy.

- There were safe systems and processes in place for medical prescriptions. Hospital private prescription

pads were in use. These were kept securely in the pharmacy department and signed in and out by nurses or the consultant as required. A record of this was kept within pharmacy.

**Incidents**

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

- Staff knew what incidents to report and how to report them. The hospital used an electronic incident reporting system.
- The service had no never events. Never events are serious patient safety incidents that should not happen.
- The service had reported no serious incidents.
- Between June 2018 and June 2019, there were 42 incidents reported by the outpatient department. Clinical assessment and patient information were the most frequently categories reported.
- Staff understood the duty of candour (DoC). The DoC means providers of care have a duty, as soon as practicable after becoming aware that a notifiable safety incident, to inform the patient that the incident has occurred, provide reasonable support and offer an apology.
- There had been no incidents within the service to trigger duty of candour. However, managers said they had access to the hospital duty of candour policy which they would follow.
- Managers said there was a robust incident review process they followed, in line with the hospital policy. Records showed that incidents were investigated thoroughly.
- There was evidence of learning from incidents with action taken to improve safety. Staff were able to describe lessons learnt. For example, staff raised an incident about patient healthcare records being left in a consulting room. Staff were aware of this and departmental meeting minutes from February 2019 showed that this information had been disseminated to all staff.
- There were systems and processes in place to respond to relevant external safety alerts, recalls, inquiries, investigations and reviews.

## Are outpatients services effective?

Not sufficient evidence to rate

We did not rate effectiveness of the outpatient service.

**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 ensured that relevant best practice guidance, such as The National Institute of Health and Care Excellence (NICE) guidelines, were identified and implemented. Records showed that the hospital's Clinical Governance and Risk Management Committee reviewed new emerging evidence-based practice and made changes to hospital policies.
- We checked 12 hospital policies and found five were not up-to-date. For example, the hospital's policies for waste management, group medical gas and record keeping were not up-to-date as the review dates had passed.
- The provider told us that their systems have a tracker that alerted them to upcoming review dates for policies, and these are then reviewed. This may result in the policy not changing, but the review dates being updated, or a change being made which required ratification at the next available governance meeting, which take place quarterly. If the provider is aware of relevant national guidance that is due to be updated, they delay updating the relevant policy, so that it can be updated efficiently in line with the new guidance, where needed. These processes and cycles of update do occasionally result in the policy that is being used, having a review date that is awaiting update through this process, however the policy remains valid until it is replaced.
- Staff in the outpatient service had a good understanding of local policies and were able to access them using the hospital's intranet.

- The outpatient referral criteria showed the service did not accept referrals for patients living with an unstable, serious mental health issue. Staff demonstrated knowledge of the referral criteria and knew how to escalate concerns.
- Standard forms and protocols were followed in certain clinics. For example, there were forms for pre-assessment anaesthetic advice, blood pressure monitoring and conversion to procedure. These were completed in the patient's healthcare records we reviewed.
- There was evidence that the standard forms and protocols reflected national based practice. For example, the "STOP-Bang" screening tool was used. This is a national screening tool used to assess likeliness of obstructive sleep apnoea.
- Technology and equipment was used to enhance the delivery of effective care and treatment. The hospital invested in improved and state of the art technology. For example, the service had recently purchased a new piece of optical equipment which was able to provide highly accurate laser optic measurements for each part of the eye.

**Pain relief**

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

- Patient healthcare records we checked showed that pain was assessed when required using the hospital's standardised assessment tool.
- Staff said that anaesthetic reviews were always carried out for patients prior to admission for surgery. Patients healthcare records we checked showed this was either planned with a date set or had been carried out.
- Through discussion with nursing staff we found that pain relieving medicines were prescribed, administered and recorded in patient healthcare records accurately. We checked two patient healthcare records which confirmed this.
- Patient's pre-assessment healthcare records showed that post-operative pain relief was discussed at their pre-assessment appointments and documented.
- There was evidence that the Faculty of Pain Medicine's Core Standards for Pain Management (2015) were used. For example, there were three consultants employed by the provider who had achieved competencies and experience in advanced pain management. The hospital also provided us with a detailed written explanation which showed compliance with each of the core standards.

**Patient outcomes**

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

- The outpatient department participated in the following national audit programmes: Patient Reported Outcomes Measures (PROMS) for hips and knees; and EQ5D Score and EQ5D-VAS Scores, which are both instruments for generic health assessment.
- PROMS questionnaires were completed by all NHS patients prior to hip and knee surgery and six months after their surgery. The questionnaires were designed to measure the health gain that patients feel following their surgery. The hospital then reported results and other patient outcome data to NHS England, who published these results on a quarterly basis.
- The service collected patient data for the Spinal Registry and National Joint Registry. A registry collects extensive clinical and patient outcome data for those who undergo certain operations. The information is analysed and used to increase clinical understanding and improve standards of care.
- The service did not participate in any peer review process with other similar hospitals.
- There was a local audit programme within the department. This included health and safety audits, such as environmental risk, and hand hygiene and record keeping audits. Audits were carried out by audit leads who were nursing staff. We spoke with two leads who said they had completed additional training to support this role. Clinical Governance and Risk Management Committee Meeting minutes from January and February 2019 showed that local audit from all departments was reviewed monthly.

- Local audit outcome was good. For example, in January 2019 an audit of how long it took for medicine prescriptions to be dispensed for outpatients had been carried out. Results showed that on average it took 13 minutes for dispensing.
- In March 2019 an audit to determine the safe storage of medicine was carried out. Results showed that 14 of the 15 standards had been met in outpatients. The one standard not met was due to medicines in labelled foil strips being kept loose in the cupboard. A labelled tray for loose foiled medicines had been put in the cupboard subsequently. We saw no loose medicines when we carried out our medicine checks.
- Managers used information from the audits to improve care and treatment. They then shared outcomes with staff and made sure staff understood information from the audits. For example, a manager said that a recent environmental audit had identified that patient's healthcare records had been left in locked clinic rooms at the end of clinic. However, outpatient meeting minutes from February 2019 showed that staff had been reminded to ensure rooms are empty, with clinical records stored in line with the hospital policy. Staff we spoke with were also aware of this learning.

**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 hospital's, "Company and Local Induction Policy", which was in date and version controlled. The policy stated new starters completed a structured corporate and local induction programme. This included the allocation of a "buddy" who was an existing member of staff to support them and an induction checklist. Staff said they had completed an induction in line with the hospital policy.
- Managers supported staff to develop through yearly appraisals. All staff had received an appraisal in the last year. Staff said that appraisals were effective, with training needs identified and planned.
- Staff said that training opportunities were good and that they were supported to develop their skills and knowledge.
- Training records showed specific staff were provided with specialist training to meet their learning needs and to cover the scope of their individual role. For example, nursing staff working in ophthalmology services (eye care) had completed specialist training to support this role.
- A manager said that the human resources department provided them with a monthly report to show outpatient staff compliance with mandatory training and Nursing Midwifery Council registration status for nursing staff.
- Nursing staff said they attended regular one-to-one meetings with their line manager. This was an opportunity to discuss any matter.
- Managers said that sub-speciality clinics were only run by clinicians with the required training in the field. They also told us that they would challenge any unfamiliar member of staff who turned up to work and escalate to senior managers immediately.
- Managers promptly identified poor or variable staff performance and supported staff to improve in the first instance. They confirmed they would follow the hospital policy and procedure which they were familiar with. For example, the hospital's, "Responding to Concerns and Remediation Policy".
- Systems and processes were in place to ensure that consultant's practising privilege were kept up-to-date. There was also a practising privileges policy which was followed; however, the review date of January 2018 had passed. This meant the policy was not in date.
- Doctors received a practising privilege handbook, which reflected the hospital's practising privilege policy and procedure.

**Multidisciplinary working**

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

Good

# Outpatients

- Staff of all grades and roles, supported and worked well together to provide patient care. Consultants, nursing and support staff and allied healthcare professionals said the entire multidisciplinary team worked together well.
- The outpatient service employed a specialist plastic surgery nurse who regularly worked alongside a consultant plastic surgeon.
- Patient healthcare records showed all necessary staff were involved in assessing, planning and delivering care and treatment. It was also clear who had overall responsibility for each patient's care. For example, one patient's healthcare record we reviewed showed that their care was led by a consultant, they had been seen and assessed by the pre-assessment team and physiotherapy staff were also involved.
- Nursing and allied healthcare professional staff said consultants led the majority of patient care, in a coordinated way when different teams, services or organisations were involved.
- All members of the multidisciplinary team were encouraged to attend the department meetings which were held monthly. Meeting minutes from January and February 2019 showed these were well attended with a set agenda. Staff we asked said copies of meeting minutes were sent to staff who could not attend meetings.

**Seven-day services**

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

- The outpatient service was open between Monday and Friday 8am to 8pm, with a Saturday service from 8am to 4pm.
- The hospital was open 24 hours a day, seven days a week, which meant patients were able to contact the hospital at all times for advice and support.
- Staff said they could call for support from doctors and other disciplines within the hospital at all times. For example, the Resident Medical Officer.

**Health promotion**

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

- We saw information in patient areas promoting healthy lifestyles and support.
- Patient healthcare records showed that staff assessed each patient's health at every contact and provided individualised care to support a healthier lifestyle. For example, one healthcare record we checked showed that smoking cessation had been discussed.

**Consent, Mental Capacity Act and Deprivation of Liberty**

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

- There was a hospital policy for mental capacity and deprivation of liberty safeguards, which was in date with version control. Staff were able to access this through the intranet. We found that this policy reflected best practice and relevant legislation, for example, the Mental Capacity Act (2005).
- Staff understood how and when to assess whether a patient had capacity to make decisions about their care. They could describe the hospital policy on mental capacity and deprivation of liberty safeguards.
- Consent to care and treatment was gained from patients in line with legislation and guideline. Patient healthcare records showed consent to treatment was clearly recorded and obtained in line with hospital policy.
- All staff had completed yearly Mental Capacity Act and Deprivation of Liberty Safeguards training.

## Are outpatients 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.**

- We saw receptionists spoke discreetly with patients at the reception area.

- Medical secretaries used work space in an area close to, but separated from, the outpatient seating area. The decision had been made to seat the medical secretary outside the consultant's room for the duration of the clinic to make booking further appointments and other allow face-to-face communication with patients. Privacy screens were used and there was very little likelihood of private information being overheard. The provider had tried to balance the need for privacy with an improved patient experience.
- Patients were offered a chaperone when intimate or personal care was being given. Notices were displayed about this throughout patient areas. Staff confirmed this happened and said that same gender chaperones could be also be arranged.
- Staff always took time to speak with patients and those close to them in a kind and respectful manner. For example, we saw one nurse sitting next to a patient in the waiting area smiling and chatting to them.
- Patient healthcare records showed staff considered patient's personal, cultural, social and religious needs and how they may relate to care needs. Pre-assessment documentation was structured and covered these areas. From the healthcare records we checked, we saw that these pre-assessment records were fully completed.
- Patients said staff treated them kindly and well. One patient told us, "Staff are always lovely here". Another patient told us, "I have been here a couple of times now, and, yes absolutely staff are kind and they smile".
- Staff respected patient's dignity. We saw staff knocking on clinic room doors and waiting for a response before entering. They also used curtains around clinic beds in these rooms when patient examinations took place.
- Staff said they would raise concerns about disrespectful, discriminatory or abusive behaviours.
- Through discussion with nursing and allied healthcare professional staff we found that staff respected the individual needs of patients and showed non-judgemental attitude.
- The hospital participated in the national Friends and Family Test (FFT) survey. Results from the FFT for March, April and May 2019 were good. For example, in May 2019 results showed that 97% of patients and visitors would extremely likely or likely recommend the service to their friends and family. However, response rates were low each month compared to attendances. For example, in May 2019 there were 5182 attendance with only 78 (1.5%) responses to the survey.
- Records showed that appropriate action was being taken to improve FFT response. Outpatient department meeting minutes dated February 2019 showed that outpatient staff were reminded to handout the FFT, which we saw.
- Compassion and care audits were distributed to patients attending pre-assessment clinic. Patients were asked to rate specific questions relating to their care. Results from March, April and May 2019 showed 100% compliance with expectations set by the hospital. Patients also gave their opinion of care which was positive. One patient had written, "Staff were very compassionate", and other said it was a, "First class service" they received. The response rate was not recorded, however, the results showed that each month between three and eight patients had participated in the audit.

**Emotional support**

- Staff said they provided patients and those close to them with advice and emotional support as required. They spoke with patients who were emotionally distressed in a private area to ensure their privacy and dignity was maintained.
- The hospital employed a psychologist for the outpatient department, who doctors could refer patients to if patients needed extra emotional support.

**Understanding and involvement of patients and those close to them**

- Staff communicated with patient's in a way they understood their care and treatment. For example, we saw one nurse speak with an older patient who had slight hearing loss. The nurse bent down to the patient in the chair, made good eye contact and spoke slowly. The patient understood what the nurse was saying.

Good

# Outpatients

- Patients said that they understood how and when they would receive test results and their next appointment date.
- A manager explained that patients received copies of the routine letter sent between the hospital and their GP, following consultation in the outpatient department.
- Patients said they understood their care and treatment; were given options and sufficient information to make informed choice.
- Staff said that patients were informed in advance if there was a planned change to their appointment, or as soon as possible if their consultant was off work unexpectedly. They gave an example of where this happened recently when a consultant was off sick unexpectedly. As soon as staff were aware of the absence they contacted patients immediately to inform them and rebooked the appointment.

## Are outpatients 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.**

- Managers said that clinics were arranged according to demand for each speciality.
- Patients said they had been offered choice in appointment date and time and saw the same consultant which supported continuity of care.
- Facilities and premises were appropriate for the services being delivered. The department was spacious, had sufficient and comfortable seating, toilets, refreshments and newspapers.
- Patients said there was sufficient car parking available when they arrived for their appointment. Public transport was within close proximity to the hospital.
- The department was clearly signposted, and there was a staffed reception at the entrance of the hospital. We saw that patients and visitors easily located outpatients.
- Patients said they were provided with sufficient information prior to appointments. This included hospital contact information, consultant name and information about any tests being carried out.
- The service offered out-of-hours clinics on weekdays in the evening and on Saturdays.
- A manager explained that telephone appointments were available at request and where appropriate, as alternative to face to face appointments. They gave examples of where this had taken place.

- Staff ensured that patients who did not attend appointments (DNA) were contacted. They followed the hospital DNA policy which we saw on the intranet. The procedure involved calling and sending a letter to the patient in the first instance.

**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 co-ordinated care with other services and providers.**

- Staff showed us that patient information leaflets could be made available in a variety of different languages. This was done through the hospital intranet system.
- All areas of the outpatient department, including toilets were accessible to wheelchair users or those with limited mobility. Automated doors allowed easy access to the reception area and there was open level access from here to the waiting areas.
- All staff had received dementia training as part of mandatory training.
- Staff said they were able to access translators and signers for patients where needed.
- There was a café in the outpatient department where patients and relatives could purchase food and drink.
- The service did not offer a one stop clinic for patients with specific needs. A one stop service allows patients

to access multiple services, such as different diagnostic tests, at one appointment. The hospital managers said that a recent review had been carried out across the provider's hospital to determine how these clinics could be potentially implemented.

- Seating of different heights was available to allow people who found getting up from low chairs difficult, to sit down. Seating was heavy and stable, to ensure it allowed people to push themselves up without the chairs tipping.

**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 could access the service through a GP referral or by contacting the provider directly, if self-funded.
- Services were available to privately funded, health insured, and NHS patients through the NHS Choose and Book service.
- Clinics were held on Monday to Friday between 8am and 8pm, and Saturdays in line with demand.
- Referral to initial consultation times were good. Between March 2018 and February 2019 patients waited between 1.4 and three weeks for their first consultation from the time they were referred.
- Patients said they had accessed their initial consultation seamlessly and quickly.
- Between June 2018 and June 2019, rates for patients not attending their outpatient appointment ranged between 4 and 7%.
- Between June 2018 and June 2019, cancelled outpatient appointment rates ranged between 10 and 18%. However, results showed that appointment cancellation rates were reducing overtime. Between March to June 2019, cancellation rate were consistently below 11%.
- Patient healthcare records we checked showed that pre-assessment nurses made sure they started discharge planning as early as possible.

**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.**

- Information about how to raise a concern was clearly displayed throughout the outpatient department. Staff we asked knew how to handle a complaint in line with the hospital policy.
- Between June 2018 and June 2019 there had been two complaints raised about the outpatient service. Concerns raised were due to car parking being difficult, poor staff attitude and clinical decision making.
- Records showed that both complaints were investigated thoroughly by managers in line with the hospital complaints policy. Patients received feedback from managers after the investigation into their complaint. There was one learning opportunity from these complaints which was about car parking.
- Managers disseminated information about complaints to staff and learning was used to improve the service. We saw evidence of this in the departmental and clinical governance and risk management meeting minutes we reviewed dated January and February 2019.
- Staff we spoke with were familiar with recent complaints about the service. For example, they knew one complaint was about car parking not being available and that staff subsequently were reminded to use dedicated staff parking.

## Are outpatients services well-led?

Good

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

**Leadership**

**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 was led locally by a nurse manager and deputy nurse manager. At the time of inspection, the manager was covering the department in addition to the inpatient department. This was due to the actual manager being on long-term planned leave. They said that they felt well supported by senior managers and were able to carry out their dual role effectively.
- Managers had the skills, knowledge and experience to lead the service effectively. Training records we checked showed that managers had achieved suitable leadership qualifications.
- Staff said that managers were visible and approachable, with senior managers also carrying out daily walk rounds of the service. We noted good interactions between managers and frontline staff.
- Managers were able to tell us the challenges to service quality and sustainability, and that they identified actions to address them. For example, a manager explained that not all staff were able to attend monthly team meetings due to not being on duty. Subsequently, at nursing handover key information was disseminated to ensure staff were kept up-to-date.
- Leaders were proud of their service and the teams that delivered them.
- The January and February 2019 Medical Advisory Function meeting minutes showed senior managers followed the hospital policy for granting practising privileges.
- Records showed doctor's practising privileges were reviewed six months after granting and then a minimum of every two years or when necessary. However, the maximum review period for medical partners without a substantive NHS contract was every 12 months.

**Vision and strategy**

**The service had a vision for what it wanted to achieve and a strategy to turn it into action.**

- Staff understood the vision, values and strategy for the hospital, and their role in achieving them. The hospital vision was displayed in large text in the foyer of the outpatient department.
- We saw that the hospital had a realistic strategy for achieving the outpatient service's priorities which included delivering good quality, sustainable care. There was evidence that progress was measured against this strategy monthly by the senior leadership team.
- Staff told us that the vision, values and strategy had been developed using a structured planning process which included collaboration with staff and external partners.

**Culture**

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.**

- Staff said they felt supported, respected and valued. They enjoyed and were proud to work for the organisation.
- From speaking with staff and patients we found that culture of the outpatient's department was centred on the needs and experience of people who used the service. It encouraged openness and honesty at all levels.
- The overriding ultra was to support the development of positive behaviours and pride in the care and treatment they delivered. However, managers were clear that action would be taken to address behaviour and performance that was inconsistent with vision and values, regardless of job role.
- Staff of all levels said they felt able to raise concerns without fear of retribution. Managers gave examples where this had happened, and they said that senior managers were supportive and prompt to take action as a result.
- Effective systems and processes operated to ensure staff at every level were provided with the support and development they needed. This included high-quality

appraisal every year. Training was monitored constantly through the hospital human resources department who had access to a live training dashboard.

- Nursing staff said there was an emphasis within the service on their safety and well-being. For example, there were staff social events organised regularly and they had their break they were entitled to.
- Several staff mentioned that the hospital was a good place to work and much nicer in terms of management support, and team working than other places they had worked previously.

**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.**

- A clear governance framework was in place. There were structures, processes and systems of accountability within it, which were regularly reviewed and improved.
- The hospital's "Governance and Assurance Framework" issued in June 2016 version 4 outlined groups and individual responsibilities. Staff were clear about their roles and understood what they were accountable for and to whom.
- Arrangement with partners and third-party providers were governed and managed effectively, which promoted coordinated, person-centred care. This included managing and monitoring service level agreements the provider had with third parties.
- Team leaders were clear about their understanding of the governance and the role they played in ensuring shortcomings were identified and acted upon.

**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.**

- There were systems and processes in place to ensure that risk, issues and performance were regularly reported on, monitored and managed effectively. For example, there was a hospital-wide risk register. Managers were familiar with the content and could access an up-to-date version. The register was reviewed regularly.
- Two risks of the risk register were specific to the outpatient's department. These were due to a hot water return issue in the physiotherapy unit and lone working out of hours. Records showed that appropriate action was being taken in relation to these risks.
- There were regular staff meetings which were recorded, with necessary information disseminated to staff. This included monthly outpatient department meetings and hospital-wide clinical governance and risk management meetings. There were correlating action plans for these meetings.
- There was a programme of clinical and internal audit to monitor quality and operational processes, with systems to identify where action should be taken. However, there were no patient record audits except for the pre-assessment records. This meant the provider could not be assured of the quality of record keeping in the outpatient service.
- Managers understood the hospital's major incident policy and could access an up-to-date version of this. The policy included events such as fire, disruption to staffing and facilities. It was up-to-date, and version controlled.

**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.**

- Managers had a holistic understanding of service performance, which integrated patient's views with information on quality, operations and finances.
- The service performance measures were clear. These were presented on the hospital's dashboard, which was reviewed monthly by senior managers at

numerous meetings. For example, elements of this dashboard were reviewed monthly during the Clinical Governance and Risk Management meeting with an action log kept.

- Staff said they had access to all the data they required to carry out their role effectively. We saw this during inspection where nurses accessed blood results and consultants had the patient healthcare records for their clinic.
- Patient's healthcare records could be requested and accessed by the service at all times. These were kept on site in a records library with electronic records kept of records taken and returned.

**Engagement**

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

- Patients and those close to them were encouraged to give feedback about their views and experience of the service. This included via the Friends and Family Test and the hospital compliments and complaints system. Feedback led to improvements in service delivery.

Good

# Diagnostic imaging

| | |
|---|---|
| Safe | Good |
| Effective | Not sufficient evidence to rate |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |

## Information about the service

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings.

### Are diagnostic imaging services safe?

Good

We previously inspected diagnostic imaging jointly with outpatient services, so we cannot compare our new ratings directly with previous ratings.

**Mandatory training**

**The service ensured staff completed mandatory training in key skills. Although high percentages of staff completed both e-learning fewer and the face-to-face elements of their training.**

- The provider had a mandatory training policy which set out the training requirements for staff and the frequency of updates. Training was delivered via e-learning modules and face-to-face training. The face-to-face training was for areas where e-learning would be less effective such as moving and handling and life support.
- Over all mandatory training completion rate at the hospital for clinical staff was 85%, and 92% for non-clinical staff. Staff working in diagnostics had an e-learning compliance rate of 98%. E-learning training included basic life support, dementia awareness, health and safety, manual handling and infection control.
- Face-to-face training included moving and handling, basic life support and or immediate life support (depending on role) and fire prevention and awareness. Of the 13 permanent staff, 11 had completed either face-to-face basic life support or immediate life support training. The two who had not completed it were booked on courses.The provider has assured us that this has now been completed.
- The two bank staff, had not completed any of the three modules for face-to-face training. The radiology lead had begun to book staff into training where needed, two permanent staff had been booked into face-to-face intermediate life support training for 6 August 2019. Following the inspection, we were assured this was now complete.

**Safeguarding**

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

- All staff, including administrative staff, working in diagnostics were up-to-date with their annual safeguarding adults and children and young people training.
- Staff we spoke with knew what constituted a safeguarding concern, how to recognise different types of abuse and how to manage a safeguarding incident in line with the hospital's policies and procedures. In the reporting period from March 2018 to February 2019 staff we spoke with, had not needed to raise a safeguarding concern.

Good

# Diagnostic imaging

- There was a dedicated safeguarding lead within the hospital which all staff knew when we asked. Four members of the hospital leadership team had undertaken training for level 3 safeguarding, and a lead consultant surgeon for paediatric safeguarding. CircleReading also had a named paediatrician was who available for support if required.
- Staff could access the hospital's adult and children's safeguarding policies and procedures via the staff intranet system. We found that staff had access to sufficient, up-to-date information to support them to manage safeguarding concerns effectively. This included contact information for the local social care safeguarding team.
- There was a hospital Safeguarding Children and Adult Policy issued in May 2018 with a three-year review date. The policy clearly outlined the process staff should follow to manage a safeguarding concern. It was also reflective of necessary legislation and publications such as The Care Act (2015) and the Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children (2015). There was also reference to Female Genital Mutilation (FGM). This ensured staff awareness of their responsibilities if they identified a woman who had undergone FGM.

**Cleanliness, infection control and hygiene**

**The service generally controlled infection risk well but cleaning was not always well documented.**

- We saw that staff decontaminated their hands regularly in line with the "My 5 Moments for Hand Hygiene" by the World Health Organisation (WHO). Staff also ensured that they were bare below the elbows. The service had conducted monthly hand hygiene audits for the reporting period from March 2018 to February 2019 and 100 percent staff compliance achieved.
- There were sufficient hand gel dispensers, hand washing facilities and personal protective equipment (PPE) such as gloves and aprons, which we saw staff using appropriately. There were also hand cleaning notices displayed reminding staff and visitors to clean their hands.
- All diagnostic clinical areas were visibly clean and had furnishings which were clean and well-maintained.
- The hospital had s infection control and prevention policies, which were in date. Staff could access these via the intranet. For example, "Hand Hygiene Policy" which was issued January 2018 had a three-year review date. Also, the "Prevention of Inoculation Injuries and the Occupational Risk of Blood Borne Viruses Policy" issued in January 2018 had a three-year review date.
- Annual infection control training was mandatory for all staff. Records showed that 100% of staff were up-to-date with this training.
- Disposable curtains were in use to screen patients when in the patient preparation area which were dated. The date indicated when they came into use and when they were due to be renewed. The disposable curtains were in date and not visibly soiled.
- In the magnetic resonance imaging (MRI) unit, staff had a weekly cleaning checklist. The dates did not correlate to cleaning checks being weekly. There were no signed dates between the 10 April 2019 and 1 May 2019. Therefore, there was a risk that equipment in the environment might not be clean. However, cleaning records for items of equipment had been signed daily in X-ray and fluoroscopy. The cleaning record included a check of the patient call alarm.

**Environment and equipment**

**The design, maintenance and use of facilities, premises and equipment were appropriate and kept people safe.**

- There was not a sign above the room where fluoroscopy (an imaging technique that uses X-rays to obtain real-time moving images) was undertaken. A senior member of staff told us a sign would be placed on the door when the room was in use for fluoroscopy.
- There was a warning sign above the door where ionising radiation was undertaken in relation to X-rays.
- Following the inspection, the provider sought the advice of a Radiation Protection Adviser who confirmed the arrangements were acceptable. The provider also introduced additional signage subsequent to the feedback.

- If a clinical emergency occurred, staff had access to the resuscitation trolley in the outpatient department. Resuscitation equipment was available, and the checking history showed this equipment had been checked daily from 01 June 2019. The equipment was fastened with a tamper proof clip and the checking records showed that once per week a thorough check of the equipment took place.
- MRI equipment and devices were clearly labelled in accordance with Medicines and Healthcare Products Regulatory Agency (MHRA) 2015 recommendations. All items within the controlled area were labelled according to MRI safety standards.
- The service used a Picture Archiving and Communication System (PACS) system, to store patient images. The hospital had a business continuity policy, in case there was an equipment breakdown, which included the PACS system, to ensure continuity of the service.
- Staff wore lead aprons when appropriate. These were screened annually to ensure they were not damaged. After an audit earlier this year, four lead aprons had needed to be disposed of. The radiology senior member of staff told us there had not been a need to purchase any new lead aprons, as there had been an excess. This demonstrated good oversight of the condition of protective equipment.
- Staff wore radiation exposure devices, which were checked annually. The 2018 staff radiation dosage report was compiled by a radiation clinical scientist and reviewed and approved by the Radiation Protection Advisor. The report recommended that for theatre staff waist badges could be withdrawn, with collar badges provisionally maintained. This was because of historically very low results, indicating dose constraints would not likely be exceeded.
- However, if there was a request for wearing the personal dosimeter (a device that measures dose uptake of radiation) by staff, this was provided. Also, if there were any changes in the practise or a new procedure was started, staff would need to be monitored for period of six months to confirm that doses remained low.
- Equipment in the department was maintained in line with manufacturers' requirements. The radiology lead explained that all the radiology equipment was contracted with the manufacturer directly, so they looked after services and repairs. The hospital had a detailed asset register which clearly recorded when equipment required maintenance and when this had been completed.
- Radiographers undertook quality assurance tests on equipment used for imaging. We saw standard operating processes detailed how the tests should be undertaken and records of the tests completed. The guidance was clear that if there were any fails the medical physics department should be contacted.
- Staff disposed of clinical waste safely. There was a Service Level Agreement (SLA) with an external company for the disposal of clinical waste. However, one of the five sharps bins we checked did not have the hospital and department box completed. This meant the sharps bin would not be able to be tracked back to the hospital if needed.
- The last electric safety testing date that was on the fridge in the clean utility was September 2017. Following our inspection, the fridge was electrical safety tested by the facilities manager. The hospital told us the fridge temperature and humidity calibration was outstanding. As a result, staff at the hospital took the fridge as out of service until the electro-biomedical engineering service undertaken.

**Assessing and responding to patient risk**

**There were systems and processes in place to identify and respond to risks.**

- Six of the seven consultants had undertaken Ionising Radiation (Medical Exposure) Regulations training for orthopaedic consultants in 2019. One consultant needed updated training with regards to the use of the mobile image intensifier in theatres, which had been organised for 25 July 2019. The training included the Local Rules.
- Post inspection we received confirmation that radiography staff using the mobile image intensifier had read and then signed the local rules dated February 2019. The rules had been signed by 13 radiography staff in February 2019 and two radiography staff in June 2019.

Good

# Diagnostic imaging

- The service had experienced an issue with referral forms having four points of patient identification. This was important to ensure the right patient received the right diagnostic test. During our inspection a consultant reviewing patients in the outpatient's department was asked to complete the four points of identification, when a referral was received without the four points of identification being fully completed. The chair of the medical advisory committee had sent an email to the consultants prior to our inspection to remind them that there must be four points of patient identification on the referral forms. X-ray requests were received from approved referrers which included GPs, consultants and allied health professionals.
- Pause and check refers to the Society of Radiographers operator check list which prompts radiographers to confirm the patient and investigation. The Society of Radiographers (SOR) 'pause and check' process was used by staff in ultrasound and fluoroscopy where interventional procedures undertaken. A poster was displayed in the X-ray room but not in the ultrasound, MRI or fluoroscopy rooms. The service had been undertaking audits of the use of the checklist. At the last inspection in August 2016, audits of the checklist had not been undertaken in diagnostics. The radiology lead shared with us the last three-monthly audits. Two of the monthly audits had achieved 99% and the third a 100% compliance.
- The service used information to improve the service. There was a protocol for when sonographers saw 'critical pathology' they could refer to a radiologist without delay. The new radiology lead had reviewed two risk assessments in relation to patient handling that may be needed in the department.
- CircleReading X-ray Procedures had been reviewed to check they complied with Ionising Radiations (Medical Exposures) Regulations 2017 IR (ME) R17 and published in February 2019.
- Local rules, as required under the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R), were displayed in the X-ray room. All areas which utilise medical radiation in hospitals must have written and displayed local rules which set out a framework of work instructions for staff. Staff were required to review these annually and when legislation was updated.
- The local rules for the use of magnetic resonance imaging (MRI) equipment were last updated in 2016. The Medicines and Healthcare Products Regulatory Agency (MHRA) states the local rules should be reviewed and updated at regular intervals and after any significant changes to equipment. The term 'regularly' was not defined further by the MHRA. The radiology lead told us the MRI rules were being updated at the time of inspection.
- Staff acted to minimise patients repeat exposure to radiation for investigative procedures. For example, staff identified when duplicate requests for X-rays were submitted. The completion of these requests placed patients at risk of repeated and unnecessary radiation exposure. Staff identified this as a concern and shared this with referrers when necessary.
- There was a standard operating process in diagnostics, to protect any patients who may be pregnant. A radiographer commented how they had noticed the pregnancy status of patients was consistently completed when they went to theatres to undertake X-rays.
- Radiographers used a screening process to find any pre-existing clinical conditions which may affect performance an investigation. For example, patients with an impaired kidney function received a reduced dose of contrast media. Contrast media are substances which increase the contrast of structures or fluids within the body used in certain types of radiological investigations. Staff checked patients, who needed a contrast media, were not allergic to any substances prior to administering the medicine.
- To prevent patients from having the wrong investigation they were asked to confirm their identity prior to an investigation being completed. Information relating to the patients' name, address, date of birth and expected investigation technique was discussed between the patient and the member of staff on arrival to the department.
- There was a 'stop the line' procedure which staff knew and instigated when there was a serious risk to

patients. A radiographer we spoke with told us they had almost used this when there had been a problem with the viewing of scan images on computers, and consultants had needed to go into the X-ray room to view images. The staff member told us the issue had been promptly responded to by the IT department. The radiographer found having the 'stop the line' procedure helped to manage patient risk.

- The radiology lead told us a radiologist reviewed all MRI referrals before patients were booked for an appointment. On arrival for their appointment, patients completed an MRI safety questionnaire to ensure their safety in the MRI scanner room. Radiographers checked the completed referral forms prior to the patient being allowed access to the MRI suite. A staff training room next to the MRI suite had been re-located, to ensure staff were not at risk of harm caused by the strong MRI magnet.
- The resuscitation training officer undertook resuscitation scenarios at the hospital, as part of staff training. The last resuscitation scenario in the MRI suite had been in November 2018. To ensure staff awareness of the precautions that must be applied within MRI, a further scenario was planned within the two months following our inspection in June 2019.

**Allied Health Professional staffing**

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

- The department was led by a radiology manager who had been in post since January 2019. The department had a radiographer establishment of seven whole time equivalent staff, three part-time radiographers, one radiology assistant and two administrative staff.
- The radiology lead told us at the time of our inspection, there were two whole time equivalent radiographer vacancies. The radiology lead told us bank staff were used to cover radiographer absence when needed. However, recruitment was ongoing with interviews planned the day after inspection.
- Two radiographers supported the magnetic resonance imaging department when clinics took place. Staffing of the X-ray, ultrasound, theatres and fluoroscopy modalities was flexible depending on service demand.

**Medical staffing**

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

- The consultant radiologist team were provided by a third-party consortium. At the time of inspection, 19 consultant radiologists had practising privileges at CircleReading. Practising privileges are an established process within independent healthcare where a medical practitioner is granted permission to work in an independent hospital. The provider reported that during the preceding 12 months, there had been no instances in which a radiologist had their practicing privileges revoked or suspended.
- Radiologists were the lead clinicians for the ultrasound and fluoroscopy service, with support from the radiology department assistant and radiographers. The consultant radiologist team also reported on the diagnostic imaging X-rays and scans that took place in the department.

**Records**

**Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.**

- The service had electronic and paper records. Staff required paper records prior to patients' diagnostic investigations. These included patient referrals, 'pause and check' process checklist and consent forms. Staff stored all paper documents in a locked room at the end of each business day. Staff scanned all paper records into the picture archiving and communication system (PACS) following the diagnostic procedure. Staff then disposed of the paper record into the confidential waste bin as per the hospital policy.
- The service used one electronic record keeping system. Radiology patient information was directly integrated into a picture archiving and communication system (PACS). The electronic record system included

a password protected record of patient's demographics and could be used to book patients into vacant investigation slots. PACS was the system for storing completed images and the associated reports. A staff members role determined the information they could access to protect patient confidentiality.

- The service maintained comprehensive electronic patient records on PACS, with details of all investigations, findings, and all radiation exposure details.
- Electronic records were secure. All computers seen were password protected and locked when not in use. If computers were sited close to patient areas, they were turned to prevent patients reading confidential information.
- Referrals to the service for imaging were completed in two different ways, by paper referral or by electronic referral.

**Medicines**

**The service used systems and processes to prescribe, administer, record and store medication, to ensure patients safety.**

- Radiology staff undertook point of care blood tests to ensure it would be safe to administer contrast medicines to patients where needed for their scan. The three radiographers that undertook point of care testing had completed the required training. The point of care testing was undertaken with the use of a dedicated machine.
- We checked where the Gadolinium was stored, and this was in a locked medicines cabinet and was in date.
- 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.**

- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. From March 2018 to February 2019, the hospital reported no incidents classified as never events for diagnostics.
- There had been one radiation incident involving accidental exposure to radiation in September 2018. A radiographer undertook an X-ray in theatres when a consultant did not have a lead apron on. The incident was reviewed by the Radiation Protection Advisor (RPA) on 1 April 2019, and the doses of radiation received by the patient and consultant were not reportable to the Care Quality Commission or the Health and Safety Executive.
- Following this radiation incident, the RPS advised that they had reminded all radiographers of the importance of checking the entire theatre to assess if all members of staff are wearing lead coats before exposures are undertaken. The RPA advised the responsibility is with the radiographer and consultant to make sure that equivalent radiation protection is worn before a procedure starts.
- The RPA recommended the radiographer and consultant should update their radiation protection training to avoid future incident. This showed that where incidents occurred they were responded to appropriately.
- In diagnostics from March 2018 to February 2019 there had been 20 clinical incidents reported and across diagnostics and outpatients there had been 26 non-clinical incidents reported. There had been one theme in relation to incidents. Staff had reported four incidents that related to communication among internal and external teams. Staff had investigated these incidents, and for three there had been no harm and one low harm.
- Notices and leaflets throughout the service informed patients and those close to them how to raise comments and concerns.
- Staff said there were numerous ways that they could be involved in the planning and management of the service. For example, during departmental meetings.

Good

# Diagnostic imaging

- Consultants said they were encouraged to be engaged with developments in their speciality and with the wider hospital.
- The Clinical Chair for the hospital kept consultants up-to-date through monthly bulletins. A consultant said that this bulletin was informative and useful.
- Staff gave us multiple examples of where their view had led to change in service. For example, pre-assessment nursing numbers had increased due to staff raising concerns that there were not enough before. Subsequently, four pre-assessment nurses were recruited.

## Are diagnostic imaging services effective?

Not sufficient evidence to rate

We do have sufficient evidence to rate effective**.**

**Evidence-based care and treatment**

**The service provided care and treatment based on national guidance and evidence-based practice. To support the service to meet the Ionising Radiations Regulations 2017 (IRR17) there was a Radiation Protector Advisor, a radiation protection supervisor and a medical physics expert for the department.**

- The service was subject to the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) and guidelines from the National Institute for Health and Care Excellence (NICE), the Royal College of Radiologists (RCR), the College of Radiographers and other national bodies. We saw standard operating procedures and policies that followed this guidance.
- The service provided care and treatment based on national guidance and evidence-based practice. The service was working to the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) and guidelines from the National Institute for Health and Care Excellence (NICE), the Royal College of Radiologists (RCR), the College of Radiographers and other national bodies.
- There was a named Radiation Protection Advisor (RPA), from the local trust, whose role was to advise on the development, implementation, monitoring and review of the policy and procedures to comply with IR(ME)R regulations.
- The hospital had a service level agreement with a local trust medical radiation physics team who provided scientific support, advice and guidance on IR(ME)R regulations concerning the use of imaging equipment and monitored the radiology equipment and any staff radiation doses.
- In line with IRR17, the imaging department appointed a radiation protection supervisor whose role was to ensure staff followed the trust standard operating procedures and adhered to the radiation protection procedures. IRR17 requires employers keep exposure to ionising radiations as low as reasonably practicable.
- National diagnostic reference levels (DRLs) were displayed in the X-ray imaging area, and dated 2018, so were relatively new. DRLs are typical doses for examinations commonly performed in diagnostic imaging departments. The objective is to ensure that, for each given procedure in an X-ray room, local exposures are kept significantly below the national levels. If DRLs for standard size patients consistently exceed the national DRLs then reasons for the differences should be investigated and corrective action taken, if possible. A clinical scientist undertook a radiation dose survey for 13 procedures undertaken in the department the department in November 2018. National diagnostic reference (NDRLs) levels were only available for three of the procedures carried out in the department, and the department performed well against the NDRLs. One value was significantly lower, and the report advised the department to ensure diagnostic quality was being maintained.
- To meet the requirements of the Ionising Radiations Regulations 17 (IRR17), the local medical radiation physics team also undertook annual quality assurance audits. This included verifying dose readings of radiation in relation to equipment used for X-rays.

**Nutrition and hydration**

**Staff ensured patients had enough food and drink to meet their needs and improve their health.**

- Patients were advised on whether they could eat or drink prior to their treatment when appointments were booked, the information was also included in appointment letters. The preparation for a scan where patients could not eat or drink anything for six hours before their scan, highlighted to patients the need to inform staff prior to their appointment if they had diabetes. This enabled radiology staff to seek advice from the radiologists about how to ensure these patients had enough to eat and drink, to ensure patients did not suffer any harm from the preparation required for the scan.

**Pain relief**

**Staff assessed and monitored patients regularly to see if they were in pain or discomfort and gave advice about pain relief.**

- Pain relief was not routinely used in diagnostic imaging because for most procedures, it was unnecessary. Patients were advised by staff and in information leaflets when they may experience pain following a procedure, for example, for a short period following an X-ray guided injection into their knee joint. Staff gave advice on the best way for patients to manage any pain experienced for the first 24-48 hours following the procedure.
- Staff told us some patients were advised when procedures may be uncomfortable. Staff reassured patients and kept them informed of the length of time remaining for procedures.

**Patient outcomes**

**Staff monitored the effectiveness of care and treatment, although this was not always shared with the provider. Following our inspection, a new process was agreed.**

- The radiologist's consortium attended a two-monthly meeting for radiologists, which included learning from discrepancies. The Royal College of Radiologists recognises discrepancy reporting processes as a means by which services can learn collectively from radiology discrepancies and errors and therefore improve patient care. When we reviewed the meetings records we could see the meetings were well attended by the radiologists and learning from discrepancies included.
- The reporting by radiologists was also peer reviewed at the local trust weekly multi-disciplinary meetings. This was documented at the local trust, however there was no external audit available to the diagnostic department at CircleReading. Following our inspection, a new process was agreed with the trust to enable radiologists to share peer review audits of their work with other organisations where they worked.

**Competent staff**

**The service make sure staff were competent for their roles, which included bank staff.**

- There was a framework, reviewed in April 2019, for supporting radiographers to develop competency and experience in the use of supplementary modalities including computer tomography and magnetic resonance imaging.
- The radiology lead had also developed a competency for the radiology department assistant and administrative staff. Evidence of this was seen during the inspection. For all staff their competency paperwork was complete. For one member of staff their induction paperwork not file at the hospital, the radiology lead was following that piece of information up with the staff member.
- To meet Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) the radiology lead told us that allied health professionals making diagnostic referrals were given specific training to ensure their competency. An audit undertaken by the radiology lead included a referral audit to ensure IR(ME)R guidelines were being followed.
- We reviewed four consultant records in relation to their professional development and saw appraisals were up to date. Within the diagnostic department there was 93% compliance with appraisals.
- A radiographer we spoke with told us they had been in post about two years. They explained before they had undertaken any clinical work they had to complete mandatory training which included the local rules in relation to Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R).

**Multidisciplinary working**

Good

# Diagnostic imaging

**Radiographers, radiologists, the radiography assistant, administration staff and other health professionals at the hospital worked together as a team to benefit patients.**

- We saw radiographers, the radiography assistant and administration staff worked collaboratively to help with the patients experience in the department. Conversations between all staff were respectful and considerate. The radiology staff told us, and we observed, there were good working relationships between the imaging department, the radiation protection team and with staff in the outpatient department. We did not meet any radiologists, but the radiology staff did not express any concerns about their working relationships with the radiologists.
- The radiologists attended weekly multidisciplinary team meetings at the local trust. The radiographers we spoke with did not raise any concerns with the information available to the radiologists at the multidisciplinary meetings. We were unable to speak with a radiologist directly, as on the day of our inspection there were none present in the department.

**Seven-day services**

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

- The main diagnostic imaging department was open Monday to Saturday. The magnetic resonance imaging service was open Monday to Saturday 8am to 8pm (magnetic resonance imaging scans requiring contact to be administered were undertaken Monday to Friday 9am to 5pm), ultrasound and fluoroscopy Monday to Friday 8.30 am to 3.45pm, plain X-ray room Monday to Friday 8am to 8pm and Saturday 8am to midday to cover clinics.
- Radiographers were on-call out-of-hours to support urgent requests for imaging within the in-patient setting. A 24-hour service was also provided by the radiologists.

**Consent and Mental Capacity Act and Deprivation of Liberty Safeguards.**

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

- Staff we spoke with understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Staff could give a good account of their understanding of how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Staff training compliance with Mental Capacity Act (2005) and Deprivation of Liberty Safeguards training was 93%.
- Patients told us staff were good at explaining what was happening to them prior to asking for consent to carry out procedures or examinations. During the inspection staff we spoke with told us verbal consent was requested for all procedures, staff sought patient's permission prior to initiating any imaging.
- Discussions prior to interventional procedures Included a description of the investigation, the possible side effects and the recovery period. Patients were given the opportunity to discuss any concerns or queries prior to giving written consent.

## Are diagnostic imaging services caring?

Good

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings. We rated it as **good.**

**Compassionate care**

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

- Patients at reception were spoken to respectfully and dealt with efficiently; staff at reception greeted all patients.
- Chaperoning signs were displayed in waiting area. Staff we spoke with told us patients were asked if they would like a chaperone before a procedure was undertaken.

Good

# Diagnostic imaging

- The three patients we spoke with felt they had been treated respectfully and in a dignified way. They described staff as having a professional approach and being 'good qualified people'.
- The radiology lead, who had been in post six months, said that they were planning to develop a template to gather feedback from patients who had used the department. They also planned to ask any wheelchair users for feedback.

**Emotional support**

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

- Staff were able to spend time with patients to explain their intended procedure or scan. Where patients were claustrophobic (a phobia of enclosed spaces), patients were counselled and could spend time adjusting to being in the magnetic imaging resonance imaging (MRI) scanner before the scan started. At the time of booking longer appointments were booked, for staff to be able to provide this support.
- Staff could communicate directly with patients when they were undergoing magnetic resonance imaging scan by way of an intercom. Staff could provide reassurance to patients as well as provide updates on the duration of scans.
- The radiology department assistant had worked closely with the administration staff to ensure that administrative staff were able to provide patients with information to minimise their distress when having particular types of ultrasound.

**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.**

- The three patients we spoke with said they felt well informed of their care journey and of what to expect when they attended their scan. Radiographers were compassionate and caring and were observed reassuring patients upon their arrival to the department.
- During our conversations with radiographers and administration staff it was clear they were passionate about caring for patients and put patients' needs first.
- A member of staff told us about a discussion a radiologist had with a patient. A patient had been keen to have a procedure at the hospital; however the radiologist was concerned it would have been risky and therefore had an informed discussion with the patient and supported them to understand why it would not have been safe for them to have the procedure at hospital.

## Are diagnostic imaging services responsive?

Good

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings. 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.**

- CircleReading provided a range of diagnostic imaging services that included plain X-ray, ultra sound, fluoroscopy and magnetic resonance imaging (MRI).
- Appointment letters explained the purpose of the diagnostic tests, what patients needed to bring, and how they needed to prepare. The patients we spoke with told us they received useful information to help them plan their visit.
- There were café facilities close by within the hospital which patients and relatives could access.
- Car parking was available within the hospital grounds to accommodate for the high numbers of patients attending for diagnostic imaging or other outpatient activity within the hospital. A patient we spoke with said it had been difficult to park. There was step free access across the hospital allowing for ease of movement for people with reduced mobility or wheelchair users.

- The radiology lead told us that approximately 80% of the diagnostic work undertaken in the department was for NHS patients, to support the wider system. The remaining 20% were private and insured patients.
- To support with the accessibility of CT scans for patients twice a month a mobile scanner was on site, delivered by another provider, to meet the CT scanning needs of NHS, private and insured patients.

**Meeting people's individual needs**

**The service was inclusive and took account of patient individual needs and preferences.**

- Ward-based mobile X-ray services were available. These could be provided 24 hours a day with radiographers supporting an on-call rota. This meant patients who were too sick or those restricted to bed, immediately following surgery, could still have X-rays at any time of day or night.
- The waiting room chairs were different heights, to support people who needed a higher seat for health or other reasons. Staff had arranged the chairs so there was also room for wheelchairs.
- Interpreter services were available, and staff knew how to contact them, should the need arise.
- Staff told us that patients living with a dementia were encouraged to bring a relative with them for support. The patients booking record had a patient alert, to inform staff whether a patient was living with a dementia. Mandatory dementia and disability awareness training was at 100% for staff working in diagnostics.
- There were changing cubicles and toilets available close to the imaging equipment which afforded patients adequate privacy. In the MRI scanning area lockers were provided for patient's belongings.
- At the last inspection in August 2016, space was restricted in the diagnostic department. Although staff told us this had not presented as an issue or risk yet, there had been no consideration given to access by patients needing to attend on their bed that may require a scan before or following surgery. When we spoke with the radiology lead at the inspection in June 2019 they told us with the way the doors opened within the department, there had not been any difficulties with meeting the needs of bed patients.
- Staff working in the department told us that on rare occasions when patients were having an X-ray they would look after a young child whilst a patient was having an X-ray. The senior leadership team told us this was not the standard of practice expected at the hospital. The senior leadership had reminded staff that they cannot look after children whilst their parents and or carers were having an X-ray. We were told notices were now being displayed in the department to explain this, and the appointment letter template was being updated to include this information. A standard operating process had been developed and approved to support the practice.

**Access and flow**

**People could usually access the service when they needed it and receive the right care promptly.**

- Patients could access the service through a GP referral or by contacting the provider directly, if self-funded.
- Services were available to privately funded, health insured and NHS patients via the NHS Choose and Book service. The radiology lead told us for diagnostics the ratio was about 80% NHS patients and 20% privately funded.
- General plain X-ray services operated both a booked appointment system and general walk-in service to allow for patients attending outpatient appointments to also have plain X-rays on the same day. Whilst we were inspecting a patient from outpatients attended for a plain X-ray. The patient was attended to promptly by reception staff, with a short wait for their X-ray to be undertaken.
- The contractual agreement for referral to treatment time (RTT) was for a maximum of 18 weeks. CircleReading is within its overall RTT of 18-week target.
- All except one patient was seen within six weeks of referral.; this exceeded the contract specification.
- The radiology lead told us that if the RTT time was greater than six weeks for MRI patients, an MRI

scanning clinic would also be planned on a Sunday. The radiology lead told us that once or twice a month a Sunday MRI clinic was provided. The radiology lead also explained there was a reserve list. This meant if there was a short notice cancellation, the service would contact patients with referrals marked as urgent.

- The radiologists working at the hospital reported on the imaging undertaken in the department. The average reporting time for MRI scans was 2.3 days, fluoroscopy the same day and X-rays were under two days.
- There was a standard operating process for ensuring that any urgent or significant unexpected findings were escalated back to the referring consultant for consideration. The radiography staff we spoke with told us the system worked well and was timely. The standard operating process included a form where details of the patient and staff involved and contacted were recorded which provided an audit trail.

**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 with all staff. The service included patients in the investigation of their complaint.**

- From March 2018 to February 2019 the hospital received five complaints which related to the diagnostic department.
- We asked the radiology lead, who had been in post since January 2019, if they had received any complaints from patients. They told us they had been involved with two informal complaints, one about the attitude of a doctor, the other was related to preparation for an ultrasound scan. The patient had been told they did not have a full enough bladder for the ultrasound to be performed successfully. Following a discussion the radiology lead had with the patient, a sign was put up in the department to explain why a full bladder was needed for some diagnostic tests.
- In the diagnostic department there were complaints leaflets to support patients who may want to make a complaint. Information about how to make a complaint was also on the hospital website.

## Are diagnostic imaging services well-led?

Good

We previously inspected diagnostic imaging jointly with outpatient services, so we cannot compare our new ratings directly with previous ratings. We rated it as good**.**

**Leadership**

**Leaders had the integrity, skills and abilities to run the service. They understood and manager to 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 diagnostic imaging service was managed by the radiology lead. They had been in post since January 2019. Staff reported the radiology lead to be visible and approachable in the role and that they had made a positive difference since being in post.
- The radiology lead reported to the Head of Nursing and Allied Health Professionals. They had the knowledge and skills to undertake the role. For example, they had recognised the need to update the competency framework for staff working in diagnostics which had been completed in April 2019.

**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. Leaders and staff understood and knew how to apply them and monitor progress.**

- The overall vision for the hospital was to be a great hospital dedicated to their patients. The vision included the following principles; to continuously improve the quality and value of the care given to patients and empower people to do their best.

Good

# Diagnostic imaging

- The vision in the diagnostic department reflected the hospital vision. The vision included; to work together to ensure staff satisfaction remained high and always go the extra mile to improve patient experiences.
- The third part of the vision was to achieve accreditation (a process of validation) by 2020 with a clinical service accreditation and peer review scheme endorsed by the Royal College of Radiologists and College of Radiographers.
- The values of the organisation were; passion, disruption (not being afraid to challenge the norm or vested interest), humanity, resilience, agility and partnership. We could see these values in all the staff we spoke with and in how valued they all felt by the organisation.

**Culture**

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

- Staff told us they were happy with their work and enjoyed working at the hospital. Staff felt listened to and said they worked well as a team. Staff were focused on the needs of patients receiving care.
- The senior management team had introduced two new meetings to improve empowerment among staff. These were 'Stop the line' and 'Swarm'. 'Stop the line' meant any member of staff could stop things and 'Swarm' was a meeting staff could call of a group of staff if needed. When we spoke with staff in radiology, we asked if they had ever asked to 'Stop the line' or call a 'Swarm'. A radiographer we spoke with explained on one occasion they had been asked to provide three radiographers in theatre instead of two. This would have affected the service provided in the radiology department to patients. The radiographer involved a senior manager, and the incident resolved without affecting patients' care.
- The staff also told us that prior to their new radiology manager commencing in January 2019, they had not always felt listened to, respected and supported. The new manager was described as approachable and, "A breath of fresh air".
- Staff were aware of the duty of candour (DoC) regulation and showed this through discussion of the right application when required. The DoC is a regulatory duty which 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.

**Governance**

**Leaders operated governance processes but these did not always identify the risks and so action was not always taken to mitigate risk. Staff at all levels were clear about their roles and accountabilities. Staff had regular opportunities to meet, discuss and learn from the performance of the service.**

- The hospital had a clear governance framework. There were structures, processes and systems of accountability within it, which were regularly reviewed and improved.
- The hospital's "Governance and Assurance Framework" issued in June 2016 version 4, outlined groups and individual responsibilities. Staff were clear about their roles and understood what they were accountable for and to whom.
- Arrangement with partners and third-party providers were governed and managed effectively, which promoted coordinated, person-centred care. This included managing and monitoring service level agreements the provider had with third parties. The radiology lead told us that their working relationships with the medical physics department at a local NHS trust worked well, with contacts open and as often as needed.
- The radiology lead also attended the monthly health and safety committee meetings. The radiology lead at the meeting held in February 2019, named a new fire warden who required training. The member of staff was due to attend fire warden training 24 September 2019. However, 92% of staff working in the department were compliant with fire prevention and awareness e-learning training.

**Managing risks, issues and performance**

Good

# Diagnostic imaging

**Leaders and teams used systems to manage performance. They had plans to cope with unexpected events.**

- There were systems and processes to ensure that risk, issues and performance were regularly reported on, monitored and managed. For example, there was a hospital-wide risk register. Managers were familiar with the content and could access an up-to-date version. The register was reviewed regularly.
- Two risks on the risk register were specific to the diagnostics department. These were due to only one X-ray room being available and information governance in relation to email referrals. Records showed that appropriate action was being taken in relation to these risks.
- The last Radiation Protection Committee meeting had been held on 27 February 2019. Attendees included the radiology lead who was the radiation protection supervisor at the hospital and radiation protection advisor. There was no evidence that the risks identified in diagnostics and imaging service had been considered by the committee.
- A further meeting had been arranged for July 2019, although usually an annual meeting, as there were some outstanding actions to be completed left by the previous radiology lead at the hospital.
- There were regular staff meetings with recorded minutes and with necessary information given to staff. This included four to six weekly diagnostic department meetings and hospital-wide Clinical Governance and Risk Management Committee meeting. Actions, where needed, were identified for staff to complete.
- There was a programme of clinical and internal audit to monitor quality and operational processes, with systems to identify where action should be taken.
- Managers understood the hospital's major incident policy and could access an up-to-date version of this. The policy included events such as fire, disruption to staffing and facilities. It was up-to-date, and version controlled.
- At the time of our inspection the hospital had needed to close the hospital kitchen and use a mobile kitchen. The mobile kitchen had been placed where the mobile CT scanner was normally placed every fortnight. The senior team worked with the radiology lead to effectively manage the care and treatment of patients who had been booked for a CT scan.
- Staff re-scheduled appointments for 26 patients affected by this. Private patients were offered the opportunity to go elsewhere with information on how to book (CTs other provider information for patients) approximately 10 patients chose to move providers.
- NHS patients were delayed three weeks which was less waiting time than the local NHS, so these patients kept their appointments at the hospital. The hospital met with the mobile CT provider to see if there was alternative placement for the CT mobile to avoid delays for patients in the future.
- The hospital director met with staff from the mobile CT provider on 2 July 2019 and a secondary landing pad for the CT mobile was confirmed to eliminate the issue from occurring in future.

**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 radiology department sent staff dosimeters (a device that measures dose uptake of external ionising radiation) to be read externally regularly to monitor staff exposure to radiation. There was clear guidance of how an accidental exposure to radiation should be managed and when an outside organisation should be notified.
- Managers had a holistic understanding of service performance, which integrated patient's views with information on quality, operations and finances.
- The service performance measures were clear. These were presented on the hospital's dashboard, which was reviewed monthly by senior managers at numerous meetings. For example, elements of this dashboard were reviewed monthly during the Clinical Governance and Risk Management Committee meeting with an action log kept.
- Staff had access to policies, standard operating procedures and patient information leaflets

electronically through the electronic quality management system. Staff confirmed that this ensured information was easily accessible and up-to-date.

- The service used IT systems to collect and share information such as X-ray and scan results; staff could access patient information using the electronic system.
- Staff were 100% compliant with General Data Protection Regulation and Cyber Security mandatory training, to ensure information was stored securely and patients' privacy and security was protected. Staff were aware of their responsibilities in relation to data protection and making sure information was accurate and managed securely. We saw data protection principles followed within the department.

**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.**

- Patients and those close to them were encouraged to give feedback about their views and experience of the service. This included the Friends and Family Test and the hospital compliments and complaints system. The radiology lead and staff working in the department, told us they were considering ways they could increase feedback from patients having scans and X-rays in the department.
- Notices and leaflets in the diagnostic department informed patients and those close to them how to raise comments and concerns.
- Staff we spoke with now felt they could be involved in the planning and management of the service with the new radiology lead in post. This was supported by the visibility of the new radiology lead and during departmental meetings. The minutes of the meetings were in a staff office, used by the radiographers and administration staff, and were printed on a notice board for staff to have easy access.
- The service worked closely with the medical physics department at a local NHS trust to ensure the diagnostic imaging service was safe for patients to use.

**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 radiology lead was aiming for the diagnostic department to go paperless. Until February 2019, paper diaries had been used to plan and book magnetic resonance imaging scans and ultrasounds. Since February 2019 and the electronic booking of MRI and ultra sound appointments, staff commented how the increased visibility helped them to support patients if they should telephone with any queries about their appointment.
- The service also this year started to use secure electronic transfer through the image exchange portal (IEP) to request images from other organisations and send them to other organisations, rather than paper referrals and receipt through encrypted compact discs.

# Outstanding practice and areas for improvement

## Outstanding practice

The service had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.

The provider had invested in new state of the art ophthalmology equipment.

## Areas for improvement

### Action the provider SHOULD take to improve

- The provider should ensure that contemporaneous patient healthcare records are completed fully.