Nuffield Health

Nuffield Health Tees Hospital

Inspection report

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

Ratings

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

Summary of findings

Overall summary

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

• The service had enough staff to care for patients and keep them safe.
• The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
• Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it.
• Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions.
• The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
• Leaders ran services well using reliable information systems and supported staff to develop their skills.
• Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.
• Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

- Staff did not always record consent in accordance with national standards.
- The service should ensure that all ward areas have the appropriate flooring.
- The service should ensure that the medicines policy is consistently followed in relation to the prescribing of maximum doses.
- The service should consider routinely referring to patients' psychological and emotional needs of patients, their relatives and carers.
- The service should consider auditing patient preoperative fasting times to ensure these are not excessive.
- The service should consider how it can innovate to enable continuous improvement.
- The service should consider how it can improve at a local level utilising information and data beyond the standard performance data reported at a national level.
- The medicines policy was not always followed in relation to the prescribing of maximum doses.
- We saw no evidence of innovation from senior leaders.

Diagnostic imaging

Good

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk and managed medicines. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Outcomes for patients was good.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand the patient pathways for scans. They provided emotional support to patients.
- Leaders ran services well using reliable information systems and supported staff to develop their skills.

Summary of findings

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

However

- The service should ensure that staff have access to up to date national guidance in relation to policies and procedures in the department to meet Ionising radiation regulations 2017 (IRR 17).

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

Outpatients

Good 

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

Summary of findings

and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment or a consultation.

- Leaders ran services well using reliable information systems and supported staff to develop their skills. Nursing staff understood the service's vision and values, and how to apply them in their work. Nursing staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Nursing staff were clear about their roles and accountabilities.

However;

- The service did not have a system to record and systematically monitor did not attend patient appointments.

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

Summary of findings

Contents

Summary of this inspection

Background to Nuffield Health Tees Hospital

The hospital is commissioned locally to provide elective services to NHS patients as well as private elective treatment in orthopaedics, general surgery, endoscopy, plastics, urology, gynaecology, ENT, dermatology, rheumatology and ophthalmology.

The hospital had 30 overnight beds but did not admit emergency patients. It has previously provided some services for young people between the age of 16 and 18 years who had been risk assessed to ensure they could be nursed in an adult setting, however, patients in this age range were not currently being seen.

Nuffield Health Tees Hospital is registered to provide the following regulated activities:

• Diagnostic and screening procedures

• Family Planning

• Surgical Procedures

• Treatment of disease, disorder or injury

The senior leadership team comprises of the Hospital Director who was also interim registered manager, Matron, and Sales and Services Manager. A newly appointed registered manager was due to start in January 2022.

The hospital was last inspected in 2017 and was rated as 'outstanding' and no requirement notices were served following that inspection. There has been no enforcement action taken against this provider.

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.

How we carried out this inspection

We undertook this inspection as part of a random selection of services rated Good and Outstanding to test the reliability of our new monitoring approach.

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

Areas for improvement

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

Action the service MUST take to improve:

Summary of this inspection

Action the service SHOULD take to improve:

Surgery

- The service should ensure that all ward areas have the appropriate flooring. **Regulation 15**.
- The service should continue to ensure that consent is recorded in accordance with national standards for all patients. **Regulation 11.**
- The service should ensure that the medicines policy is consistently followed in relation to the prescribing of maximum doses. **Regulation 12.**
- The service should consider routinely referring to patients' psychological and emotional needs of patients, their relatives and carers. **Regulation 9.**
- The service should consider auditing patient preoperative fasting times to ensure these are not excessive. **Regulation 14.**
- The service should ensure that patient information is available in other languages and formats. **Regulation 9.**
- The service should consider how it can innovate to enable continuous improvement. **Regulation 17.**
- The service should consider how it can improve at a local level utilising information and data beyond the standard performance data reported at a national level. **Regulation 17.**

Outpatients

- The service should have a system to record and systematically monitor did not attend patient appointments. **Regulation 17.**

Diagnostics

- The service should ensure that staff have access to up to date national guidance. **Regulation 17.**

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Diagnostic imaging	Good	Inspected but not rated	Good	Good	Good	Good
Outpatients	Good	Inspected but not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Surgery

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

Are Surgery safe?

Good

Mandatory training

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

All staff received and kept up-to-date with their mandatory training. Staff told us that they were up to date with all mandatory training or if training was outstanding due to long term absence then required training was already scheduled to be completed on their return to work.

Training compliance data demonstrated that 92% of ward staff were up to date with required training. We saw that staff who had outstanding training had been booked to undertake the required mandatory training requirements.

The mandatory training met the needs of patients and staff at this location. Training was always completed within scheduled work time which ensured that staff had the opportunity to complete the training when required.

Managers monitored mandatory training and alerted staff when they needed to update their training. Systems were in place which allowed for the monitoring of training compliance which pre alerted managers to training that was due to expire.

However, there were no training modules on recognising and responding to patients living with mental health needs and learning disabilities.

Safeguarding

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

Nursing staff received training specific for their role on how to recognise and report abuse. The level of training received met and exceeded the national guidance on the level of training for healthcare staff.

Nursing and medical staff received training specific for their role on how to recognise and report abuse.

Good

Surgery

Safeguarding training compliance for level two was 80% for ward nursing staff which was beneath the completion target of 85%. We raised safeguarding training with ward management during inspection and we were told that whilst this was beneath the location target, it was due to staff on long term absences such as illness or maternity leave.

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

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

Not all staff had direct experience of making a safeguarding referral but all staff we spoke with knew how to make a safeguarding referral and who to inform if they had concerns. All staff could identify the safeguarding lead within the organisation.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. We observed regular enhanced cleaning that was documented as being completed.

Some non clinical areas on the ward had carpeted floors. This posed a potential risk of infection. This was raised during inspection and we were told that plans were already progressing to have it removed. The service provided action plans relating to its removal.

The service generally performed well for cleanliness and staff used records to identify how well the service prevented infections. We saw a local audit programme which included assessment of cleanliness as part of an ongoing process. We also saw an action plan that addressed any highlighted issues.

Staff followed infection control principles including the use of personal protective equipment (PPE). All staff were observed to use PPE correctly and all staff followed the principles of Bare Below the Elbow (BBE). We saw hand hygiene audits completed between January 2021 and December 2021 showing 95% compliance.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed equipment being cleaned between patient use. We also saw equipment being cleaned and stored with labels documenting when it was cleaned before storage.

Staff worked effectively to prevent, identify and treat surgical site infections (SSIs). The service reported no notifiable SSIs between 2020 and 2021.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. We saw during inspection that staff responded quickly when patients requested assistance.

Good

Surgery

Staff carried out daily safety checks of specialist equipment. We saw that daily safety checks were undertaken and recorded. We reviewed records and saw no omissions in the completion of records.

The service had suitable facilities to meet the needs of patients' families. The ward had allocated a room to allow family members to stay overnight to support relatives undergoing surgery

The service had enough suitable equipment to help them to safely care for patients. Staff told us that they had enough equipment to do their job properly. We were also told that any replacements were ordered and delivered promptly.

The resuscitation trolley was situated on the ward and was stocked correctly. We reviewed all check lists completed by staff and saw no omissions or errors.

Staff disposed of clinical waste safely. We saw all clinical waste sharps bins were used and stored in accordance with national guidance.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. We saw that the National Early Warning System 2 (NEWS2) system was being used and that there was clear evidence within patient records that it was being utilised effectively. Local audits for the completion of NEWS2 reported 94% compliance for the last quarter of 2021.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. In all 10 records that we reviewed we saw assessments for the risk of pressure area damage, falls, malnutrition and venous thromboembolism (VTE). We saw evidence of staff using risk assessments when things had changed for a patient and making adjustments based on that information.

Staff knew about and dealt with any specific risk issues. Staff were able to give examples of how they managed risk issues such as sepsis and VTE, we also saw examples of additional learning around these subjects in the form of ward-based training.

Staff shared key information to keep patients safe when handing over their care to others. We observed that staff followed the World Health Organisation (WHO) five steps to safer surgery. We saw that compliance with this standard was audited, we reviewed the audit from November 2021 which demonstrated 100% compliance.

Shift changes and handovers included all necessary key information to keep patients safe. We observed shift handovers which included situation, background, assessment and recommendation (SBAR).

Nurse Staffing

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

The service had enough nursing and support staff to keep patients safe. We saw that the service achieved a staffing level of one registered nurse for every five patients.

Good

Surgery

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance.

The ward manager could adjust staffing levels daily according to the needs of patients. We saw examples of nurse staffing being increased in response to patient need.

The number of nurses and healthcare assistants matched the planned numbers.

The service had low overall vacancy rates with less than one whole time equivalent (WTE) vacancy on the ward.

The service had low turnover rates which equated to staffing establishment being at 98%.

The service had low sickness rates of 6% overall. The ward had less than 1% staff sickness.

The service had low rates of bank nurse usage.

Managers utilised the provider's bank staff when required. All bank staff were currently well established and familiar with the service. We were told that agency staff were never used as they always had access to enough bank staff.

All bank staff were employed by the provider on zero hours contracts, all had the correct training, a full induction and understood the service.

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. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. The service employed two Resident Medical Officers (RMO) who worked opposite each other on a one week on and one week off shift pattern.

Both RMOs undertook all mandatory training and 100% compliance was demonstrated during inspection.

All consultants were not employed by the service but were operating under the practising privileges systems.

We reviewed the service's policy and processes for ensuring that all staff working under the practising privilege system and following review of three staff files we saw no omissions and that all key components were met such as General Medical Council (GMC) registration, disclosure and barring service checks (DBS), evidence of participation in the appraisal process at their employing NHS trust and evidence of ongoing professional development and completion of all mandatory training. We also saw clear processes for communication between the service and the employing NHS trusts.

The service always had a consultant on call during evenings and weekends. The service's deteriorating patient policy provided guidance on when to escalate concerns to a consultant. We were told that all consultants on call had to be based within 30 minutes travelling time and any delays would be reported through the provider's incident reporting system.

Good

Surgery

Records

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

Patient notes were comprehensive, and all staff could access them easily. We reviewed 10 sets of patient records and found them complete and without omission.

A local audit of patient records for from October to December 2021 demonstrated 74% compliance, recurring themes had been identified and additional training sessions were being held to ensure all staff completed records appropriately. Managers told us that they had also spoken directly to staff on an individual basis.

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

Records were stored securely.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. The medicines policy was not consistently followed in relation to the prescribing of maximum doses.

Staff generally followed systems and processes to prescribe and administer medicines safely. Medicine charts were regularly reviewed by the pharmacy service.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. We saw that patients were counselled on discharge and their discharge medicines were available in a timely manner.

Staff completed medicines records accurately and kept them up-to-date. Medicine and prescribing audits were undertaken on a regular basis with actions and improvements recorded.

Staff stored and managed all medicines and prescribing documents safely. Controlled drugs (medicines with specific storage requirements) were stored securely and we saw evidence of the necessary checks. Controlled stationery such as prescription pads were stored securely and only accessible to authorised personnel. Records were kept to ensure the service had an audit trail.

Staff learned from safety alerts and incidents to improve practice. Medicine incidents were recorded and reviewed appropriately with actions taken and lessons learnt

The medicines policy was not always followed in relation to the prescribing of maximum doses.

Incidents

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

Staff knew what incidents to report and how to report them. All staff were able to describe how the incident reporting system worked.

Good

Surgery

Staff raised concerns and reported incidents and near misses in line with provider policy. All staff were able to give examples of incidents that they had raised. All staff stated that there was a no blame culture and that incident reporting was encouraged and not seen as punitive.

Managers shared learning about incidents with their staff and across the trust. All staff were aware of a recent incident in ophthalmic surgery, this had been communicated by email and through face to face contact with ward managers.

Managers shared learning with their staff about never events that happened elsewhere. Staff were aware of incidents that had occurred in different areas of the hospital and within the wider organisation.

Staff reported serious incidents clearly and in line with policy.

Staff understood the duty of candour. They were open, transparent, and gave patients and families a full explanation if and when things went wrong. All staff were aware of their responsibilities with duty of candour and could give examples of when it had been applied.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us that they received emails following investigations of incidents and they were also discussed at ward level.

Staff met to discuss the feedback and look at improvements to patient care.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident.

Are Surgery effective?

Good

Evidence-based care and treatment

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

Due to the service's admission and exclusion criteria, we were told by senior management and ward-based staff that it would be unlikely that patients with enduring mental health conditions or those under restrictions of the Mental Health Act would be treated. Staff told us that the pre-assessment process would identify that their needs would best be met at the local NHS trust.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We saw examples of the service following National Institute for Health and Care Excellence (NICE) guidance, such as the use of a nationally recognised early warning system for the recognition and response to patient deterioration.

At handover meetings, staff did not routinely refer to the psychological and emotional needs of patients. Staff were able to give examples of how they would do this if required.

Good

Surgery

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. They used a nationally recognised screening tool to monitor patients at risk of malnutrition. We reviewed 10 sets of patient records and saw accurately completed fluid and nutrition records in 100% of records.

We were told that due to the admission criteria that it would be unlikely that staff would need to access specialist support such as dietitians and speech and language therapists. Staff were able to access these services at the local trust if they were required.

We saw no evidence that patients waiting to have surgery were not left nil by mouth for long periods. We were told that fasting times were reviewed. Following our inspection visit we saw that the service had a policy concerning perioperative fasting which followed best practice guidance. We requested any audits undertaken to ensure compliance with the policy, but we were told that this was not audited, therefore, we were not assured that patients were being fasted appropriately.

Pain relief

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

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

Patients received pain relief soon after requesting it. We spoke with 10 patients who reported that pain relief was given in a timely manner.

Staff prescribed, administered and recorded pain relief accurately. We reviewed five prescription charts and saw that pain relief was prescribed and records of administration were completed.

Patient outcomes

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

The service participated in relevant national clinical audits.

Outcomes for patients were positive, consistent and met expectations, such as national standards. We saw examples such as the service achieving 99% in Patient Reporting Outcome Measures (PROMs) for knee replacement patients.

The service had a lower than expected risk of readmission for elective care than the England average. Less than 1% of all patients required unplanned readmission between October to December 2021.

Good

Surgery

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. We saw that the service had and followed a comprehensive annual audit programme.

Managers used information from the audits to improve care and treatment. We saw evidence of action plans that had been created following audit completion.

Managers shared and made sure staff understood information from the audits. We saw examples of feedback from audits displayed in staff areas and we were told that audit feedback would also be shared electronically across all teams.

Improvement was checked and monitored. We saw a comprehensive audit programme which ensured robust review and actions to improve if required.

Competent staff

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

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

Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work. We saw that 92% of staff had received an annual appraisal within the year, we also noted that staff who had not received their appraisal had one booked in.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff told us that emails were regularly sent and that ward management would speak to individuals if required.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. All staff told us that they did not have to complete training in their own time and additional opportunities were given to complete training in work time.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. We spoke with a member of ward staff who had successfully undertaken further training which allowed for them to progress from a non-clinical role to a clinical one.

We were given examples of proactive management identifying opportunities for staff to develop and to facilitate career progression.

Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve. Senior ward staff had a clear process for identifying and supporting staff whose performance was not to an acceptable level.

Multidisciplinary working

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

Good

Surgery

Staff held regular and effective multidisciplinary meetings on a monthly basis to discuss patients and improve their care. These meetings were minuted and if staff could not attend the meeting minutes were made available. Consultants were also invited, and we were told that they would attend if they were available.

Staff worked across health care disciplines and with other agencies when required to care for patients.

All staff told us that teamworking was a major positive within the organisation and that all disciplines worked well together.

Staff could not give any examples of when they had referred patients for mental health assessments when they showed signs of mental ill health. We were told that patients living with mental health conditions would be assessed for suitability prior to admission and redirected to the local NHS trust if it was felt this would better meet their needs.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including diagnostic tests, 24 hours a day, seven days a week.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on the ward. Although, we did not see health promotion material in any other language or format than English.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent but did not always accurately record consent when given.

We were told that due to the admission and exclusion criteria any patient who was deemed to lack capacity and who would not be able to consent to treatment would be highlighted during the pre-assessment process and arrangements would be made to treat them at the local NHS Trust**.**

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care but due to the admission and exclusion criteria staff were unable to give examples of when they had to do this.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed consent being obtained by staff prior to any interventions or routine care.

Staff made sure patients consented to treatment based on all the information available.

Good

Surgery

Staff did not always clearly record consent in the patients' records. We reviewed 10 sets of patient records and saw five examples of where a patient had consented to treatment prior to admission but had not been consented again on admission.

A local audit completed between October and December 2021 highlighted that consent was completed in only 74% of cases reviewed. This had been identified as an issue and we saw that additional training sessions had been set up to address the low compliance. We were provided with further audit results around consent following inspection which demonstrated 95% compliance.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. We were told that 16 and 17 year old young people could be admitted for treatment, but this happened infrequently.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The completion rate was 89%, which was within target.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Are Surgery caring?

Good

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness.

Patient satisfaction surveys were regularly used, we reviewed responses between August and October 2021 and all were positive with a 98% satisfaction rate.

Staff followed policy to keep patient care and treatment confidential.

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

We saw examples of staff who had undertaken additional training in understanding anxiety.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Good

Surgery

Emotional support

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

Staff told us that they gave patients and those close to them help, emotional support and advice when they needed it.

Staff told us that they supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff told us that there was no training given on breaking bad news but always demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We observed staff explaining processes and procedures with patients and giving them opportunity to ask questions.

Staff talked with patients, families and carers in a way they could understand, but we were told that communication aids were not available.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw that patients were given the opportunity to give feedback both during and after their admission and in a variety of methods such as email, online or through routine telephone follow up.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service. We saw multiple examples of positive feedback that had been received. Patients told us that they were included in care and treatment plans and were given support to understand when needed.

We saw that a room on the ward would be made available to allow a family member to stay and support a patient if required.

Are Surgery responsive?

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.

Good

Surgery

Managers planned and organised services so they met the needs of the local population where appropriate. The service supported the local NHS trust and would take NHS funded patients.

Staff knew about and understood the standards for mixed sex accommodation. All inpatients were in private rooms so there was no opportunity for mixed sex breaches.

Facilities and premises were appropriate for the services being delivered.

Staff could not access emergency mental health support 24 hours a day 7 days a week for patients living with mental health problems, learning disabilities and dementia. Senior management told us that they had never needed this service due to the service's admission criteria. Ward staff told us that if urgently needed they would arrange for a patient to be seen at the local NHS Trust.

The service did not have systems to help care for patients in need of additional support or specialist intervention due to the admission criteria streaming those patients to the local NHS trust for treatment. We were given one example of an informal arrangement with the tissue viability service at the local NHS trust to provide advice on a casual basis.

Meeting people's individual needs

The service was generally inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. The service did not have information leaflets in different languages nor access to communication aids.

The ward was not designed to meet the needs of patients living with dementia. Changes had been made to a specific room on the ward to make it dementia friendly, however, the remaining environment was not designed to meet the needs of this group of patients, who were not routinely seen by the service.

Staff supported patients living with dementia and learning disabilities by using their existing 'This is me' documents and patient passports. Staff gave us one example of a patient being admitted who used a 'This is Me' document.

Staff understood but had infrequent opportunity to apply the policy on meeting the information and communication needs of patients living with a disability or sensory loss.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters when needed. Staff gave us examples of when interpreting services had been used.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

The service did not have information leaflets available in languages spoken by the patients and local community.

Staff did not have access to communication aids to help patients become partners in their care and treatment.

Access and flow

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

Good

Surgery

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Waiting times for all specialties were currently better than national standards.

Managers and staff worked to make sure patients did not stay longer than they needed to. The current average time on ward was two days.

Managers worked to keep the number of cancelled operations to a minimum. We saw less than 1% of operations had been cancelled between October and December 2021.

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. We saw that four operations had been cancelled in the preceding three months and all had been rebooked at a time to suit the patient.

Managers and staff worked to make sure that they started discharge planning as early as possible.

Staff planned patients' discharge carefully to ensure effective discharge. We saw that staff would routinely contact patients following discharge to ensure there were no issues and to offer further advice and guidance if required.

Staff supported patients when they were referred or transferred between services. Patients were only transferred in accordance with the deteriorating patient policy to the local NHS trust. Two patients had been transferred within the last three months which was less than 1% of all patients treated.

Managers monitored patient transfers and were aware of national standards.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. We witnessed staff routinely advising patients on how to make a complaint if they needed to.

The service clearly displayed information about how to raise a concern in patient areas. We did not see information displayed in languages other than English.

Staff understood the policy on complaints and knew how to handle them. We reviewed three examples of complaints received and the responses made. All were dealt with in accordance with the provider's policy.

Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We saw examples of feedback sent to patients and it was in accordance with the provider's policy.

Managers shared feedback from complaints with staff and learning was used to improve the service. Information from complaints was shared routinely with staff and discussed.

Good

Surgery

Are Surgery well-led?

Good

Leadership

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

All service leaders had the skills and knowledge to run the service. They were able to articulate the priorities and the issues the service faced.

Staff across all grades and roles reported that the senior management team was visible and supportive and they had no concerns raising queries or concerns to them.

Staff gave us examples of how the leadership team had identified talent and developed staff to reach their professional goals. Staff reported that all members of the leadership team were inclusive and encouraging.

Vision and Strategy

The service did not articulate a vision for what it wanted to achieve nor could they describe a strategy to turn it into action.

We were not assured that the leadership team was sighted on an overall vision and strategy for the service. Senior leaders were unable to describe what the strategy was for sustainable improvement nor could they articulate how they would achieve this. We did note that there had been recent changes in the senior management structure with managers from other hospitals within the organisation providing cover and that a new permanent senior manager was due to commence.

We did not see examples of how the service was monitoring improvements beyond the standard performance data reported at a national level.

Culture

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

All staff told us that they felt respected and valued. Managers acknowledged achievement, good care and hard work. We saw that there was a staff acknowledgement programme that identified and rewarded staff.

Staff told us that delivering excellent patient care was everyone's main priority.

All staff reported that working within the service was a positive experience with many staff returning to the organisation. There was a high number of staff returning following student placements once qualified.

Good

Surgery

We were given examples of staff being encouraged to work in new roles and being given access to additional training to achieve career progression.

We were told that the culture was one of no blame and all staff being treated equally regardless of role or grade.

All staff were aware of their responsibilities under duty of candour. Staff could give us examples of when duty of candour had been applied. We saw examples of when duty of candour had been applied.

Patients told us that they were encouraged to provide both positive and negative feedback. All patients we spoke with felt that they could raise any concerns without worry.

Governance

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

We saw a robust governance system in operation with all staff aware of their roles and responsibilities.

We reviewed the minutes from the last three governance meetings and saw that governance meetings were regularly held, these were well attended with all hospital departments represented, key issues were discussed, and reviews were undertaken when necessary. These meetings were minuted and made available to staff who had not been able to attend. The meetings contained discussions of performance in order to improve.

There was a robust system in place for the monitoring of staff employed under the practising privileges system which included effective communication between the provider and a consultant's employing trust. We saw evidence of regular checks, monitoring and open dialogue in all practising privilege records that we reviewed.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

We saw that the provider had a risk register which had all identified risks, dates of entry, dates for review, mitigations and staff allocated to manage each risk. We were assured that senior staff escalated risks where necessary.

We saw robust systems and processes being utilised to manage performance. We were assured that the senior management team had sufficient oversight of performance to identify areas that required improvement.

Staff told us that their opinions were sought by senior management when decisions were needed to be made.

Information Management

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

We saw examples of how data was collected and analysed. All data was available to the staff who required it.

The information system was largely computer based with access limited to staff with individual password protection. Paper based records were used but there was a clear policy for the retention and destruction of paper records once scanned onto a patient's individual records.

We noted all staff locking computers between use.

All data and notifications were submitted when required and in a timely manner.

Engagement

Leaders and staff actively and openly engaged with patients and staff, Due to the COVID 19 pandemic engagement with external groups was currently paused.

Prior to the COVID-19 pandemic, public engagement was a regular occurrence with teams going to public events to promote the service and to increase local access, currently due to current guidelines this had been delayed but we were told of plans to recommence as soon as possible.

We saw multiple methods of how the service currently engaged with the public utilising such methods of surveys, feedback cards, follow up phone calls and being encouraged throughout their patient journey to give both positive and negative feedback. We reviewed three patient surveys and other feedback and it was all mostly positive. Any negative feedback was treated as equally valuable and we saw examples of management writing to dissatisfied patients.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders were not able to articulate nor give examples of ongoing innovation.

We were assured that leaders had a good understanding of how to monitor and improve quality and had the skills to do so.

We were told about plans to improve services which included streamlining the day case admission process so that patients would not need to be admitted onto the ward but would be treated in a bespoke day case area. There was also discussion being held about expanding the gynaecological service currently being offered to increase the number of treatment options available.

All staff were committed to learning and to improving services as it was clear that optimal patient care was at the centre. We saw examples of learning being shared throughout the service.

We saw no examples of innovation; we requested any work that demonstrated innovation and none was provided. We spoke with members of the senior leadership team and whilst they could describe service improvement, they could not describe nor give examples of innovation.

Good

Diagnostic imaging

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

Are Diagnostic imaging safe?

Good

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.
Radiologists, radiographers, health care assistants and administrators received and kept up-to-date with their mandatory training.

The mandatory training programme was comprehensive and included: infection prevention control, basic life support, safeguarding and mental capacity act training ensuring staff had the skills to support people with additional needs such as dementia and learning disabilities. Compliance with mandatory training was 99%. Radiography staff completed radiation protection training each year, and compliance for the department was 100%.

Most mandatory training was accessed electronically. Annual face to face training included: basic life support, fire safety, moving and handling and infection prevention. There was a system in place which monitored mandatory training and staff were alerted by email when they were due an update.

Staff told us that the team received reminders to their email two weeks prior to the renewal date of any training. They expressed no issues booking training sessions prior to their renewal date due to most of their training being virtual on the internal academy online system.

Included in mandatory training for senior radiographers, radiographers and health care assistants was training on each of the equipment in department, the overall compliance was 93%.

Safeguarding

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

Good

Diagnostic imaging

Nuffield Health provided three levels of safeguarding training and staff received the appropriate level specific to their role. We saw that safeguarding training compliance was 100%. The hospital matron was the designated adult safeguarding lead. Both the matron and radiology manager had completed level three adult and children safeguarding. In accordance with the safeguarding children and young people intercollegiate document (2019), radiographers had completed level two and administration staff completed level one.

Staff we spoke with were able to access safeguarding policies and procedures and knew who to escalate concerns to. To their knowledge all staff told us there had been no identifiable safeguarding concerns within the diagnostics department.

The hospital had systems and policies in place for the identification and management of both adults and children at risk of abuse. Safeguarding information was accessible to all staff on the intranet, and there was evidence of flowcharts displayed for identifying concerns such as procedures and guidance on identifying and reporting female genital mutilation (FGM).

The staff felt comfortable escalating concerns to the manager and understood the process of escalation to the matron if such concerns did arise in department. Information about safeguarding was displayed on the noticeboards in both offices for safeguarding escalation and appropriate contacts.

Cleanliness, infection control and hygiene

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

Clinical areas were clean and had suitable furnishings which appeared well-maintained. Cleaning records were up to date and demonstrated all areas were cleaned regularly. The monthly audit showed the department scored 95% for cleanliness in October 2021.

One of the radiographers had completed a university course and qualified as an infection prevention link practitioner. They completed their dissertation on handwashing techniques, had provided additional training to the team and had ongoing audits to monitor this performance.

All consulting/imaging rooms we inspected had hand-washing facilities, antibacterial hand gel, paper towels, cleaning wipes and personal protective equipment were available. We saw posters displaying the Worlds Health Organisation's five moments for hand hygiene. Staff were observed washing their hands before and after each patient's appointment and scored 100% for the 'hand hygiene obs' audit in October 2021.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw that hand gels were available across the department and available for staff and visitors. Personal protective equipment was available in all clinical areas and we observed staff using it appropriately. Staff followed best practice guidelines and were all bare below the elbows when within the clinical areas.

The department followed infection prevention protocol for intimate examination. All radiographers were compliant and trained on using the 'Tristel TRIO wipes system' and three radiographers had completed refresher training February, March and May 2021. Evidence of compliance was recorded in a 'Tristel Trio wipes system Quality Audit Trail Record Book'. The department had an in date standard operating procedure (SOP) for 'cleaning of endo cavity ultrasound probe XR-15' to ensure a robust cleaning system was in place.

Good

Diagnostic imaging

Environment and equipment

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

The diagnostic service was located on the ground floor of the hospital adjacent to outpatients. There was a reception shared with outpatients. The location of the diagnostics department made it easy for patients to transfer between outpatients and diagnostics.

The service had a variety of scanning rooms such as the x-ray room which was the access point to the CT and MRI scanners when on site, ultrasound, mammography. In addition to two reporting rooms where scans were reported by the medical staff which were also used as offices, three small curtained changing areas and a small waiting area. A toilet was available in the department.

The service had a maintenance contract in place to attend any faults identified in the running of equipment, staff gave examples of prompt and recording of responses to defects. All equipment was regularly serviced.

The service had enough suitable equipment to help them to safely care for patients. There were signs and warning lights outside controlled areas where radiation was used to make it clear when it was safe to enter. There was also warning signage such as 'authorised persons only' on display.

Staff wore lead aprons to protect themselves from the risk of radiation exposure. The aprons were tested six monthly completed by two radiographers in department to maintain effectiveness.

Staff radiation exposure was monitored by the radiation protection supervisor and records of dose badges were recorded. All staff wore radiation exposure devices to ensure that they were not over exposed. This was shared with relevant other employers that staff worked for. The radiation protection supervisor reported back results to staff before providing the next batch of badges. Appropriate action would be taken if overexposure was identified.

The service used a picture archiving and communication system (PACS) to store patient images to securely access and view images.

Yearly reports showed that overall management of radiation protection was good and was judged to be largely compliant with Ionising Radiations Regulations 2017.

The department had access to adult resuscitation equipment located just outside the department on the adjacent ward which could be accessed quickly in an emergency. We saw daily checks completed and all equipment was within expiry dates and stored securely. There was an anaphylactic kit which was sealed and dated.

Clinical waste was stored and disposed of appropriately. Sharps disposal bins were labelled correctly and not overfilled and did not appear to contain any inappropriate waste. There was waste disposal available in the department for clinical and non-clinical waste.

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

Cleaning records outlined responsibilities for radiology staff and housekeeping and showed cleaning on days the equipment was in use. Staff told us they carried out safety checks of specialist equipment. The necessary tests had been conducted on equipment to ensure it was safe for use before it had been used in department.

Assessing and responding to patient risk

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

The service manager was the radiation protection supervisor and a senior radiographer was the deputy radiation supervisor. The department had access to an external radiation protection advisor.

There were signs in all clinical areas and in the patient waiting room. The was a large sign in multiple languages asking patients to inform staff if there was a possibility that they might be pregnant. The department used a divider clearly labelled for patients not to 'pass at this point'. The appointment letter asked patients not to bring children with them to the appointment and there was a sign in the waiting area which stated that children must be supervised at all times.

The staff told us that they had not experienced any unplanned transfer of patients from the radiology department to another health care facility.

There were processes in place to ensure the right person got the right radiological scan at the right time. The Society and College of Radiographers (SCoR) recommends a 'pause and check' for radiographers before and after an exposure is carried out. We saw evidence of this check during an Xray.

We saw that allergies and past medical history was included in the templates and all had been recorded in the 10 patient records we reviewed.

There was a radiology department meeting in June 2021 which discussed a potential anaphylaxis following a CT contrast study. Some of the areas highlighted in the meeting were: identify potential 'at risk' patients, signs of an allergic response, action should a patient have a mild anaphylaxis and to remind staff of the contrast reaction pack in department.

The service had a third-party agreement with 'Inhealth', a mobile MRI and CT arrived onsite two to three times weekly. When the MRI and CT was onsite, there was a policy to ensure they had the correct equipment in case of an emergency. The MRI and CT radiographers had a walkie talkie, oxygen cylinder and an emergency drugs pack signed in and out of pharmacy daily on the vehicle with them. We reviewed two sets of MRI patient records and both had completed safety questionnaires.

If an MRI or CT patient did deteriorate and need emergency assistance, staff told us the two radiographers on the mobile MRI scanner vehicle would alert the radiology department who puts out a crash call. The crash trolley was closely located at the ward next door and the crash team would support.

All MRI paperwork included referral forms, radiologists protocol form, the completed MRI safety questionnaire and prescription form such as contrast, signed by the resident medical officer (RMO) on site.

Diagnostic imaging staff

Good

Diagnostic imaging

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

There were no concerns with staffing levels across the department. The manager told us they had good staff retention; we saw that actual staffing levels met planned staffing levels on all shifts. The service had low turnover rates. The service had bank staff who they could contact to provide a flexible service.

Managers told us all newly recruited radiographers had a full 12-week induction including two mentors and understood the service.

A nominated radiographer took responsibility of the department's rota. We were told that radiographers, health care assistances and administrative staff worked to set hours and therefore all shifts were covered as required. We saw that there was good oversight of the rota, rota was completed in advance it included on call shifts for radiographers and took consideration of factors such as annual leave.

Medical staffing

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

Medical staff were not managed directly by the diagnostic imaging department. The radiologists were not always on site, although staff told us they could contact radiologists by telephone if required.

Medical staff worked at the hospital under practising privileges and attended the diagnostic imaging at their set times. The granting of practising privileges was a well-established process within the organisation

Practising Privileges are a discretionary personal licence to undertake consultations, diagnosis, and treatment in accordance with relevant legislation, regulation and the General Medical Council's (GMC's) Good Medical Practice 2013 (updated April 2019).

Records

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

Patient notes were comprehensive, and all staff could access them easily. Records were a mixture of electronic and paper records. When patients transferred to a new team, there were no delays in staff accessing their records.

During the inspection we reviewed 10 patient records, these were completed as required. There was evidence of safety checklists, identification checks and magnetic resonance imaging safety forms completed.

For patients who were self-funding, the results of scans would be sent to the patient's general practitioner (GP) or referring doctor. Images were provided to the patient in the form of a compact disc (CD).

Medicines

Good

Diagnostic imaging

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

Staff stored and managed all medicines and prescribing documents safely. We saw evidence that the medicines were stored securely, and that the medicine cupboard keys were kept locked away in a cupboard.

Staff completed medicines records accurately and kept them up-to-date. Stock was checked, monitored and recorded appropriately.

The pharmacy was available for support Monday to Friday from 8.30am to 4pm, with medical staff supporting out of hours.

Staff followed systems and processes to prescribe and administer medicines safely. Allergies were identified on patient records and there was access to emergency medicines.

MRI contrast was stored in one of the clinic rooms and stored at room temperature. There were check sheets that had been completed appropriately. All the contrast was in date. The contrast/batch number and expiry dates were entered into the patient record.

Incidents

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

There had been no never events or serious incidents in the department. There had been one radiation incident in the previous two years categorised as no harm. This incident was fully investigated, learning had been considered and work to address this was ongoing.

The department staff had access to an electronic incident reporting system, staff we spoke with were aware of this incident reporting system and could describe what an incident was as well as how to report them. The manager shared incidents and discussed at clinical governance meetings. The manager stated that they fed back during morning staff meetings and monthly staff meetings dependent on the urgency.

Managers shared learning with their staff about never events that happened elsewhere. There was evidence that changes had been made as a result of feedback. A staff member talked us through an incident which was discussed in a team meeting. They highlighted that the team completed an additional check of scan type before proceeding, following information sharing from another location.

There were no incidents that required duty of candour to be applied. However, staff explained their understanding of duty of candour, which was to provide patients with an apology and to be open and transparent and give patients a full explanation when things went wrong.

Are Diagnostic imaging effective?

Good

Diagnostic imaging

Inspected but not rated

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 National Institute for Health and Care Excellence guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies and procedures were available and accessible through the hospital systems. Most policies during our inspection were found to be in date however we found a key piece of guidance was out of date which was used for the development of policies for the service. Staff in the service had access to policies such as: incident reporting, safeguards and the chaperone policy amongst others.

The service used diagnostic reference levels (DRL's) for each piece of scanning equipment that produced radiation. DRL's were used as a guide to help promote improvements in radiation protection practice. They helped identify issues relating to equipment or practice by highlighting unusually high radiation doses.

Nutrition and hydration

Staff gave patients food and drink when needed. The service made adjustments in accordance to patient needs and the pandemic.

Patients received information in their appointment letter in advance of scans regarding timescales for when they could eat and drink. This was provided at the time of booking and in the appointment letter. A staff member shared an example where they considered a diabetic patient who needed to fast for four to six hours prior to scanning. They ensured that appointments were scheduled before lunch.

The hospital accommodates patients who are vegetarian or vegan and require a low fibre diet when having a CT or MRI of the colon. The department held information for food recommendations and foods to avoid.

Water was available in the waiting room. Since the pandemic patients were requested to bring and sip their own water whilst waiting in the car for MRI/CT investigations.

Patient outcomes

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

The service had an audit calendar for health and safety, patient outcomes and patient experience. This included equipment and decontamination of equipment, infection control and personal protective equipment.

Managers used information from the audits to improve care and treatment. Hand hygiene audits did not meet expected standards. Following investigation and two repeated audits, outcomes improved to 100%.

Good

Diagnostic imaging

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvements over time. The service completed the anatomical marker audit monthly, the aim was to mark the patient at the time of scanning in line with best practice and improving patient outcomes. We were told in response to lower scores on the anatomical marker audit the service held training and practical teaching sessions. This gave staff the opportunity to actively reflect on the value of the timing of adding anatomical markers during opposed to after. The results of the anatomical marker audit did improve following these sessions.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff received appraisals including an appraisal at six and 12 months, the service had a 100% appraisal rate, these were overseen and managed by the manager in department. Staff also had one on one clinical supervision meetings two monthly, standard agendas included: trust values, objectives and an opportunity to raise any concerns.

New staff received a full induction programme to the hospital tailored to their role before they started work.

Staff had access to additional courses and training. There was access to courses to support leadership development. The department had radiation supervisors who had completed additional training for this role. The department kept a record of Health and Care Professions Council (HCPC) registration for each radiographer.

Multidisciplinary working

For our main findings please refer to the surgery report.

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

The department staff worked closely with other hospital teams and the outpatient team to provide the service to patients.

The staff told us internally they had a good working relationship with pharmacy, resident medical officer, staff on the surgical ward and outpatients.

The hospital held regular and effective multidisciplinary meetings to discuss patients and improve their care, which the radiology was invited and attended.

Seven-day services

Key services were available to support timely patient care.

The service operated routinely five days a week Monday to Thursday 8am to 8pm and 8am to 5pm on a Friday. They could offer flexibility with part time radiographer and/or bank radiographers. All staff explained that they were happy with this arrangement.

Good

Diagnostic imaging

There was an on-call radiographer scheduled 24 hours per day for general x-ray.

Health promotion

The service had relevant information promoting healthy lifestyles and support in the diagnostic imaging department.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in patients' records. Staff could describe the process for gaining both verbal and written consent.

For our main findings please refer to the surgery report.

Are Diagnostic imaging caring?

Good

Compassionate care

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

The reception was in a separate room to the waiting area so patients could speak without being overheard which contributed to privacy and dignity in the department. We saw that once patients entered the department staff introduced themselves and all staff wore ID badges.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients said staff treated them well and with kindness.

Staff followed policy to keep patients care and treatment confidential. We saw that doors were always closed during appointments.

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

Privacy and dignity were maintained as patients changing rooms were adjacent to scanning areas so patients could go directly into the scanning areas without having to access any public areas.

Emotional support

Staff provided emotional support to patients to minimise their distress. We observed staff show understanding, listened and reassured patients who felt anxious. Staff described having enough time to spend with patients during their visit to department.

Good

Diagnostic imaging

Although few patients with complex needs or learning disabilities accessed or were referred for scans, staff told us about the importance of supporting patients emotionally, socially and understood the potential challenges they faced.

A family member and carers could stay in the scanning room with patients if it was requested and appropriate to assist in supporting the patient during their scan. Patients could give feedback on the service and staff supported them to do this.

Understanding and involvement of patients and those close to them

Staff supported patients to make informed decisions about their care. Two members of staff took the time to discuss and educate the function of a MRI with an anxious patient as well as information regarding monetary requirements.

Staff were able to acknowledge when patients were not able to fully understand their care and treatment, they made sure that they also communicated with those close to the patient. We were told that staff supporting patients understanding by providing information leaflets and would regularly include this within appropriate appointment letters.

There had been a hospital patient satisfaction survey October 2021 and 91% of patients felt that they received a clear explanation about the risks and benefits.

Are Diagnostic imaging responsive?

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 service was located on the ground floor of the hospital building that was fully accessible. Within the department there was a toilet, small and clean waiting area with two chairs that were socially distanced, a water machine and a stored wheelchair. There were three different areas for changing with disposable curtains. Other rooms available could also be used for changing if needed.

There was no reception area in the radiology unit, however, in the appointment letter, patients were asked to arrive at the main reception area then were signposted to the appropriate unit. There was CCTV in the waiting area for the staff in the office so staff could see who had arrived.

The service provided MRI and CT scanning to NHS staff. There was a routine mammography screening service for self-funding patients. There was set eligible criteria for these patients e.g. non symptomatic.

Staff told us on a monthly basis the service had approximately three did not attend appointments. Not attended appointments were monitored by the staff and each patient was contacted if they did not attend.

Meeting people's individual needs

Good

Diagnostic imaging

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

The service minimised the number of times patients needed to attend the hospital by ensuring patients had access to the required staff and tests. The staff told us that on occasions patients did not live locally to the hospital and they would give the choice to return in a short space of time or refer them for scans near to where they live.

The service managed care of vulnerable service users, for example the service had the capacity to extend appointment times, choose the most appropriate time for staff to offer support and potentially book at the end of the list so the department was quieter and there was no need to rush. The department was designed to meet the needs of patients living with dementia for example in the toilet there was a blue toilet seat.

Appointment scanning times varied depending on the type of scan and needs of the patient. Depending on the procedure, there was a letter sent with the appointment to provide information about the procedure and what to do before the scan.

Patients were offered a choice of appointment times and provided with information prior to the scan here required.

Managers made sure staff, and patients, relatives and carers could get help from interpreters or signers when needed. If an interpreter was needed there was an alert on the computerised radiology information system (CRIS), staff would book either an in person or virtual interpreter.

The service did not offer a bariatric service, patients' weight was recorded in the safety questionnaire for both CT and MRI. Patients who required a bariatric scanner would be signposted for example to the nearest Nuffield or NHS trust who had the appropriate equipment.

Additional patient information would be shared with Nuffield Health by the referrer. A staff member shared with us an example where a patient diagnosed with autism required the support of a carer. The team were very accommodating, they increased the time of the appointment slot and made reasonable adjustments to ensure the patient felt comfortable during the appointment.

The hospital had processes in place to ensure they did not discriminate on the grounds of protected characteristics. The hospital had up to date equality and diversity policies and made changes to other policies in accordance to this e.g. 'childbearing' opposed to female. Equality and diversity training were part of the mandatory training programme.

The hospital was not a dementia friendly environment and were audited in the hospital's patient-led assessment of the care environment (PLACE). The radiology manager completed a dementia college course February 2020 to improve skills to support patients living with dementia. The hospital also held a dementia committee meeting which raised awareness and included members to share their personal experiences.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times for treatment were in line with national standards.

Good

Diagnostic imaging

Requests for scans were screened by a radiologist. Appointment times were allocated depending on the type of scan and any additional needs. The number of patients attending for the day was discussed at the morning department meeting.

The service used a computerised radiology information system (CRIS) to manage appointments. The staff had a list of patients for the day and could see patients booked into time slots and could manage demand from outpatients.

Managers monitored waiting times and made sure patients could access services when needed. Staff told us that patients could generally receive an x-ray the same day, mammogram and ultrasound during the same week and receiving an MRI or CT was dependent on when the mobile scanners were on site; the longest wait being one week. Urgent ultrasound scans could be done on the same day if there was a radiologist on site.

During the inspection, the manager contacted a radiologist, who was not on site, but agreed to come in for an urgent scan that day. If the radiologist was not available, the manager would signpost to the NHS.

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible. The staff shared a recent example when the mammogram scanner had a fault, the routine patients were all called and rearranged for the next week for times that suited them.

Appointment times were long enough that radiographers, radiologists and the team rarely ran behind schedule. During the inspection there was only ever one patient in the waiting room.

Reports were returned to referrers in paper format and unitelectronically.

For the month October 2021 we saw evidence of 1,320 reported scans. This information was shared with senior leadership and for this month the radiology department achieved 80% within radiology reporting turnover times.

Learning from complaints and concerns

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

In line with infection prevention control during COVID-19 the department could not display paper information. However, leaflets were stored in the offices and available to provide to patients including 'Your Opinion Matters' which included the website information to contact the complaints team directly with alternative information to complain via email or post.

The radiology manager would raise any complaints for discussion and review during clinical governance meetings, at the medical advisory committee and complaints compliments and concerns meeting for lessons learned. The department had not received any formal complaints. Managers shared feedback from complaints with staff and learning was used to improve the service.

The hospital had an up to date complaints policy and standard operating procedure. The policy stated that complaints should be acknowledged in two working days. The service aimed to resolve the complaint within 20 working days of receiving it. If both parties had not agreed a resolution, the complaint was escalated to internal review and then to internal independent adjudication.

Good

Diagnostic imaging

Staff knew where to find the policy on complaints and knew how to escalate them.

Are Diagnostic imaging well-led?

Good

Leadership

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

There was a clear leadership structure in place across the department. All staff we spoke with described the manager as being approachable and effective. There was strong leadership of the service for an efficient and caring service. All managers were known on first name terms, were approachable and welcomed questions and suggestions from staff.

The manager was focussed on quality of the service. Development was encouraged and supported within the team. The leadership structure was clear and easy for the staff to follow. There was a process in place should the manager be out of the office. Staff told us that they were supported clinically, professionally and personally by the manager, with time protected for this.

The team had a meeting every morning to discuss activities of the day and allocate departmental responsibilities such as holding the crash bleep. Any concerns were raised during this meeting and together, as a team, these activities were discussed and actioned.

Culture

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

Staff told us the department had a positive working culture and that providing high standards of patient care was the priority. The manager shared an example of an occasion when a member of staff did not work in line with Nuffield values, this was actioned, and behaviours improved, which management continued to monitor.

Staff told us had they identified training needs; the manager would support staff to take external courses for example: infection prevention control link practitioner training. A budget for training is set aside for each radiographer to attend training days and events.

The radiology manager completed a stress and anxiety for staff course in August 2021, to better support members of staff in the department. Staff were offered sessions with mental health experts.

Good

Diagnostic imaging

Managers encouraged an open and transparent culture and staff were encouraged to report incidents and complaints. The manager told us that they had not received any complaints in the 14 years she had managed the department. Staff knew how to escalate should a complaint be received, and the department sought feedback from patients when possible to identify areas of improvement. Complaints were a standing agenda item at the clinical governance meeting.

Vacancy rates were extremely low and staff retention was good. There was good communication within the department, and we observed a good sense of teamworking between all staff, as well as a friendly, open and supportive environment.

Vision and Strategy

The radiology governance lead told us Nuffield's goal was to 'get it right first time' and that the organisation would support both the radiology manager and matron as a specialist.

The department managers demonstrated a vision for the future of services. The radiology department secured investment to increase the server capacity. They were well sighted on the challenges faced by the department; some they acknowledged they would struggle to change, such as the departments space and building development opportunities. There had been changes particularly after the pandemic which improved their use of the space.

Staff were aware of the Nuffield vision and strategy. During the inspection we observed that all staff displayed behaviours in line with Nuffield values.

Governance

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

The service participated in team meetings, department meetings and clinical governance meetings. There were processes in place to ensure that all information was communicated to all staff.

There were staff meetings for the team held daily in the morning and a written record of a formal meeting held for the radiology department staff monthly. The manager told us there was a standard agenda template and agenda items included departmental updates and governance issues. We were told there is a radiology expert advisory group who discussed corporate risks related to radiology, relevant supporting information was sent to the manager via email.

There were radiologists who worked at the clinic with practising privileges. There was a medical advisory clinical group which one of the radiologists was a nominated member. This group provided assurance to the radiology department for clinical quality, customer service, local developments and supported the implementation of policies and the development and delivery of new services.

The service had a whistleblowing policy and staff were aware of who they could escalate any concerns to.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

There was an organisational risk register which included possible risks from across the organisation. Each risk included a risk rating and a review date.

Risks for the radiology department were added to the corporate risk register and reviewed at clinical governance meetings.

Information Management

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.

We observed that the service accepted images securely from external organisations to input into Nuffield systems.

The manager told us about a theme of patient images being stored in a different patient record. The service raised this issue, communicated with the team, and implemented actions to rectify the error. This was monitored to ensure no further incidences. In addition, staff told us of two occasions when a patient was sent a letter intended for another patient. Duty of candour was applied, and the department rang the patient to explain and apologise.

All policies were available on the staff intranet.

All staff received training on information governance.

Engagement

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

Patients were encouraged to leave feedback about their experience using a patient satisfaction questionnaire. The manager explained that the radiology department had their own subsection within this questionnaire. Staff told us they regularly spoke with patients to gather their feedback which was discussed during team meetings. Prior to Covid-19, the service obtained written feedback, however due to infection prevention control, the service have removed all forms and leaflets to improve infection prevention. Patients now provide feedback via the website.

Staff provided feedback to management at all levels. We were informed that there were many opportunities to do so, both formally and informally.

Learning, continuous improvement and innovation

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 department used audits to monitor the service provided and utilised action plans as required to address potential ways to improve. The staff shared an example for reviewing positions for scanning that provided a clearer image, it was more comfortable for the patient and increased ease for the radiographer.

The service recognised issues with the upload capacity for the picture archiving and communication (PAC) system, the radiology department recently secured CAPEX investment to increase server capacity.

Good

Diagnostic imaging

The department had an external mobile MRI scanner on site two to three times per week. There were current business plans to review the possibility for investment to support orthopaedic surgery.

For detailed findings, please see the well led section of the surgery report.

Good

Outpatients

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

Are Outpatients safe?

Good

Mandatory training

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

Nursing staff received and kept up to date with their mandatory training.

Staff we spoke with told us they were received an email six weeks before the need to complete a mandatory training refresher course. Staff told us they were given time to complete their training either online or face to face in the classroom.

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

Managers we spoke with told us they would receive an email informing them when a member of staff would be required to complete a mandatory training course. This allowed them to monitor completion with the individual concerned.

The mandatory training was comprehensive and met the needs of patients and staff.

The overall mandatory compliance rate for the hospital was 84% for all staff.

The mandatory training which had not met the compliance target was, the Nuffield Health Basic Life Support course 54% and Infection Prevention: Practical 76%

Managers we spoke with told us staff had been booked on the courses where the compliance targets had not been met and the monitoring systems in place would ensure they were completed.

Consultants were not employed by the provider. They worked under practicing privileges. Please refer to the mandatory training section of the surgery core service report.

Safeguarding

Good

Outpatients

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

Nursing staff received training specific for their role on how to recognise and report abuse.

Although nursing staff we spoke with had not made any safeguarding referrals, they could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

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

Nursing staff knew how to make a safeguarding referral and who to inform if they had concerns, including the police in cases of female genital mutilation (FGM).

Nursing staff we spoke with knew who the safeguarding lead for the hospital was and how to contact them for advice.

We saw evidence that appropriate staff and managers had been trained to safeguarding level three.

The safeguarding training rates at the hospital were Safeguarding Adults: Level one 86%, Safeguarding Children and Young People: Level one 89% and Safeguarding Children and Young People: Level two 75% and Safeguarding Children and Young Adults: Level three 100%. Figures were not available separately for this core service.

Managers we spoke with told us staff had been booked on the courses where the compliance targets had not been met and the monitoring systems in place would ensure they were completed.

The hospital had an overall safeguarding corporate lead and locally responsible safeguarding lead within the hospital. The safeguarding lead at corporate was level four trained and hospital lead was level three trained.

Managers and staff told us if they were suspicious of a safeguarding issue following a did not attend (DNA) appointment or throughout any other interaction within the care pathway it would be escalated to appropriate safeguarding lead.

Consultants were not employed by the provider. They worked under practicing privileges. Please refer to the safeguarding section of the surgery core service report.

Cleanliness, infection control and hygiene

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

The outpatient's department was clearly designated as a blue area in relation to COVID-19 restrictions. The blue area indicated patients and staff could enter this area as it had been confirmed they had not displayed any COVID-19 symptoms.

Good

Outpatients

Prior to patients attending outpatient consultations they were risk assessed by the pre-assessment unit. If the patient reported any COVID-19 symptoms the consultation was cancelled. All patients attending the outpatient's department were considered not to be a COVID-19 risk.

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

We inspected the outpatient's rooms used for ophthalmology consultations, ears, nose and throat consultations, minor procedures room and two rooms used for general consultations. All the equipment in each room displayed clean stickers showing they had been recently cleaned. There were clinical waste bins, sharps bins, hand gel dispensers, sinks with handwashing posters displayed near them and supplies of in date sterile wipes.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles. During the inspection we observed staff employing correct handwashing techniques, staff using hand sanitiser gel, wearing face coverings, wearing personal protective equipment (PPE) when required, and staff wiping down and cleaning after a patient consultation.

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

Patient seating in the reception area was socially distanced and kept apart. The seating had cleanable surfaces. There was hand gel dispenser near to the reception area for patients and staff to use.

There were different colour coded bins for different types of waste in the consultations rooms we inspected. Posters on the walls near the bins explained to staff which waste had to go in which colour bin.

Clinical waste was stored and disposed of safely. There were separate sharps bins with secure lids.

We saw evidence equipment which had to be kept sterile prior to procedures were kept in sealed bags. Once used the equipment was sealed in a red bag prior to cleaning.

During inspection the online training infection prevention and control training was at 90%, however face to face practical course had not hit the completion target due to pandemic restrictions. There was an action plan in place to address this, and in addition, a designated infection prevention control (IPC) lead nurse had been recruited who was due to start work in January 2022. Their role was to provide an IPC overview in the hospital and ensure any improvement actions would be completed.

Due to COVID-19 restrictions, a patient-led assessment of the care environment (PLACE) lite audit had been conducted. This had been a remote assessment, conducted by staff volunteers as the planned PLACE programme was suspended due COVID-19 restrictions.

We reviewed a copy of the PLACE lite action plan assessment. There were nine issues identified in the outpatient's department. All had action owners and monitoring in place. None of the identified issues posed a patient safety risk.

The outpatients IPC audit for October 2021 was reviewed, standard preparations scored 95%, environment 85%, hand hygiene 93% and social distancing 100%. No further actions were required.

Managers informed us due to staffing challenges the documentation of antimicrobial audits had not been completed in last reporting period, however, the pharmacy manager continued to check antibiotic prescribing and assurances were given at the medicine management quarterly meeting in November.

During inspection we reviewed the hospitals infection surveillance data from March to September 2021. There were no mandatory UK Health Security Agency reportable infections identified.

Environment and equipment

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

Staff carried out daily safety checks of specialist equipment to ensure it was clean and within the servicing schedule. In addition, that sterile equipment was stored in sealed bags ready for use.

The servicing and maintenance of equipment was carried out by a private contractor.

We saw evidence of an outpatient's assets register which recorded each piece of equipment by asset number and serial number. There were 20 items of equipment listed all had the date last serviced and when the next service was due. All the equipment listed was within the next servicing date.

Staff disposed of clinical waste safely.

We inspected the rooms used for ophthalmology consultations, ears, nose and throat consultations (ENT), minor procedures and two rooms used for general consultations. The equipment in the rooms which required to be serviced had a service sticker with the date when the next service was due. All the equipment checked was within the next service date.

Equipment in the rooms we inspected that required portable appliance testing (PAT) test had stickers which showed the equipment was within the date when the next test was required.

We checked 15 consumable sterile items of equipment in the outpatient's minor procedures room store cupboards, all were in date.

The service had suitable facilities to meet the needs of patients' families, which included drinking water, a hot drinks dispenser, toilet facilities, seating and a television in the reception area.

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

Assessing and responding to patient risk

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

Nursing staff we spoke with could explain the action they would take if a patient suddenly deteriorated while in their care. All staff were familiar with the deteriorating patient policy.

Good

Outpatients

Nursing staff told us that there was a daily test of the resuscitation alarm in the hospital. During inspection we heard the alarm being tested but we saw no records to confirm this.

Nursing staff told us they took part in resuscitation exercises where they took part in scenarios dealing with patients who required resuscitation in order to practice their training.

The hospital assessment unit completed the patient risk assessments on the aptinets arrival at hospital.

Outpatients nursing staff reviewed the pre-assessment unit risk assessments for each patient on arrival confirming the information before completing a separate risk assessment which was recorded in the patients notes.

We saw evidence in the 10 patient records we checked of risk assessments being carried out and the world health organisation (WHO) surgical safety checklists being completed as part of the outpatient pathway.

Consultants had the ability to access out of hours imaging on the hospital site.

Nursing staff told us patients could telephone a consultant if they had any concerns about their recovery from an operation or before their outpatient appointment. We were told either a telephone triage would be completed by the consultant which was recorded in the patients records or the patient would be asked to immediately attend the hospital if it was felt they were at risk.

Staff in the pre-assessment unit told us consultants would alter or increase their outpatient clinic lists and times to accommodate occurrences when they considered a patient was at risk and needed to be seen as soon as possible.

Managers told us two patient record audits had been completed since the start of this year. No issues had been identified in the patient record forms (PRFs) checked.

Nursing staff knew about and dealt with any specific patient risk issues.

The service did not have access to mental health liaison and specialist mental health support. Patients suffering mental ill health would be screened out by the pre-assessment unit as they did not meet the admission criteria. They would be referred to an NHS hospital trust.

Nursing staff told us if a patient suffered from a mental health episode whilst in the outpatient's department an NHS ambulance would be contacted to attend.

We saw evidence of a standing operating procedure (SOP) if the hospital suffered an IT system failure which was used for patient bookings. The SOP covered roles, responsibilities and actions to take to ensure no patient would be at risk caused by a missed appointment.

Nurse staffing

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

Good

Outpatients

The outpatient unit manager was responsible for ensuring there were enough staff on duty each day. The manager had access to a bank of staff who had previously worked for the provider to fill any staff shortages.

We saw evidence in the staff files we checked all staff had received a formal induction and were supported by mentors. The induction training included mandatory training either online or face to face.

The outpatient unit was staffed by a senior nurse/manager, seven registered nurses and five health care assistants.

At the time of the inspection the service had enough nursing and support staff to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance. Staffing was planned six weeks in advance taking account of the requirements of consultants which included the number of consultations by specialism, the number of consultations and the overall time these would take to complete.

Shift patterns worked varied dependant on clinical activity. There was always a registered nurse on duty supported by either two or three health care assistants covering between 8am to 9pm, apart from Saturday which covered between 8am to 1pm.

The number of nurses and healthcare assistants matched the planned numbers.

The service had low turnover rates and sickness rates.

Managers told us vacancies were frequently advertised and staff which had left the hospital were contacted to find out if they wished to be added to the bank.

The staffing vacancy rates across the hospital at the time of the inspection were; clinical permanent vacancies six, non-clinical permanent vacancies seven, clinical bank staff vacancies 10 and non-clinical bank vacancies six.

The service had 13 vacant permanent posts.

At the time of the inspection there was no staff sickness for outpatient clinical staff. There was a 0.6% sickness rate for the outpatients' administrative staff. Managers and staff told us this did not impact upon the ability of the department to carry out the administrative functions with the additional work being done by existing staff.

The service had low rates of bank nurse usage.

Managers limited their use of bank staff and used staff who had previously worked for the service. In that way managers made sure all bank understood the service.

Medical staffing

Consultants with practicing privileges from several different specialties saw patients in the outpatient department.

A resident medical officer was available at any time to review a patient if required. Clinical support was provided to them by the organisation's clinical lead.

Good

Outpatients

For our detailed findings on medical staffing, please see the safe section in the surgery report.

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.

We reviewed 10 sets of PRFs. The PRFs we reviewed were paper based. They were comprehensive and all staff could access them easily. The handwritten content was legible.

There were no gaps found in the information fields in each of the records checked.

When patients attended an outpatient's appointment there were no delays in staff accessing their records.

If the patient was an NHS referral the referring hospital used a secure email system to send the electronic patient records to the hospital. The electronic records were printed off to marry up to the paper records held by the provider.

Records were stored securely. We saw evidence patient records which were being used for outpatients' appointments during inspection were kept in a portable cabinet with a combination lock.

Patient records not in use were kept in a locked free-standing cabinet in the nurse's office.

Although no virtual clinics were held, consultants did carry out telephone triage calls with patients, the details of which were recorded in the patients notes.

Clinical notes were identified approximately 24-48 hours before the scheduled appointment. In the morning of the consultations these were taken by staff to the relevant consultation room when the consultant arrived.

We saw evidence of consultants returning patient records after the patient consultation to reception staff so they could make a future appointment if required.

Medicines

The service used systems and processes to safely administer, record and store medicines. The medicines policy was not consistently followed in relation to the prescribing of maximum doses.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Consultants used the providers prescriptions which were used by patients to obtain medication. Prescription pads were stored securely and used safely.

Staff had access to emergency medicines in the case of adverse reactions and anaphylaxis.

There were no patient group directives in place for medicines. There were no controlled drugs used or stored by the hospital

Good

Outpatients

Medicines were stored securely.

The Accountable Officer/ Registered Manager holds overall responsibility for medicines in the hospital.

The outpatient's medicines were subject to a weekly audit and stock take. No issues had been identified.

Consultants were not employed by the hospital but worked under practicing privileges. Please refer to the Medicines section in the surgery core service report.

Incidents

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

Nursing staff knew what incidents to report and how to report them.

Although nursing staff we spoke with had not raised concerns or reported incidents or near misses in line with provider policy they were able to explain how they would do this.

The outpatient's department had no never events reported.

Nursing staff told us learning about incidents and never events had been shared, including those which had happened in other Nuffield hospitals.

Nursing staff understood the duty of candour. Nursing staff gave us an example when they had used the principles of duty of candour, being open and transparent giving the patient a full explanation when something had gone wrong.

Staff met to discuss the feedback and look at improvements to patient care.

We were told there was systems in place for managers to investigate incidents thoroughly. Patients and their families were involved in these investigations.

There were systems in place for managers to debrief and support staff after any serious incident.

There were no incidents reported where surgical site infections had occurred as a result of delays or patients not being followed up appropriately.

Are Outpatients effective?

Inspected but not rated

Evidence-based care and treatment

Good

Outpatients

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

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

Nursing staff told us when National Institute for Health and Care Excellence (NICE) guidance was issued, the information was subject to a GAP analysis. The NICE guidance was compared to existing provider policies and practices to identify if any changes were required to be made to improve the service provided.

We saw evidence from a report dated October 2021 of 12 NICE guidance documents having been reviewed.

Daily departmental meetings were held where patient risks and the emotional needs of patients their relatives and carers were discussed in line with best practice.

Pain relief

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

Patient pain assessment was completed by the pre-assessment team prior to the patient's appointment.

In the 10 sets of PRFs we checked there was evidence nursing staff assessed and recorded patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

The consultants providing care and treatment were not employed by the hospital but worked under practicing privileges. Please refer to the pain relief section of the surgery core service report.

Patient outcomes

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

Managers and nursing staff used the results to improve patients' outcomes. These were discussed at team and governance meetings.

Managers shared and made sure staff understood information from the audits through team meetings and email circulations to staff.

During inspection we saw evidence of two post-operative incidents where learning had resulted which was shared with staff. Staff were knowledgeable of the incidents and were able to articulate the learning following a post-operative pulmonary embolism (PE).

Competent staff

Good

Outpatients

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.

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

Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work.

We saw evidence in the on-line appraisal system folder of how staff accessed the electronic appraisal system with a full explanation of how to complete their objectives. All staff files checked showed evidence of up to date appraisals.

We reviewed four outpatients nursing staff appraisals and saw all had manager reviews of the progress of the staff objectives.

The consultants providing care and treatment were not employed by the hospital but worked under practicing privileges. Please refer to the competent staff section of the surgery core service report.

The clinical educators supported the learning and development needs of staff.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Nursing staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

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

Multidisciplinary working

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

Nursing staff participated in effective multidisciplinary meetings when required to discuss patients and improve their care. The outpatient department manager attended multidisciplinary meetings with other hospital department staff.

Nursing staff worked across health care disciplines when required to care for patients.

We saw evidence communication with general practitioners (GPs) was done through a discharge letter, consultant review letter or pre-assessment data request.

The hospital had a member of staff who worked as GP liaison. They were responsible for engagement, communication and identification of trends through their contact with GPs.

Good

Outpatients

The consultants providing care and treatment were not employed by the hospital but worked under practicing privileges. Please refer to the Multidisciplinary working section of the surgery core service report.

Seven-day services

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

Consultants could call for support from other disciplines, including diagnostic tests when they were required, or additional support had been identified through the pre-assessment process.

There was flexibility in consultations. We saw evidence of additional appointments being added to existing lists and short notice consultations being completed.

The hospital had two registered medical officers (RMO's) working on a rota of one week per fortnight on call at all times. They could be contacted by staff for advice.

The outpatient department was open Monday - Friday 8am -8pm, Saturday 8am -1pm

Consultants only held clinics according to availability therefore no rota cover was required, however, arrangements were in place if an urgent appointment was required and the named consultant was unavailable. Another consultant from the same specialty would assist and review the request for the consultation with the matron and carry it out if the patient was felt to be at risk.

We saw evidence clinics were arranged according to consultant availability and in accordance with demand for a specialty which ensured the hospital was maximising capacity and offering services in line with clinical need.

Health promotion

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

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

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle.

Health promotion was included as part of the patient discharge process where advice was given as to how to achieve the best outcome from the procedure or minor operation which had been carried out.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Patients suffering mental ill health would be screened out by the hospitals pre-assessment unit as they did not fit the admission criteria.

Good

Outpatients

Nursing staff did explain if a patient, for example, was diagnosed with early signs of dementia they would be allocated a consultation after completion of a risk assessment and if they could attend a carer or someone who had power of attorney would attend with them to support them when consenting to treatment.

Nursing staff gained consent from patients for their care and treatment in line with legislation and guidance. We saw evidence of this in the 10 PRF`s which were reviewed.

Staff made sure patients consented to treatment based on all the information available. Patients we spoke with all told us they had been made fully aware of the risks and benefits of the procedures they were undertaking before they signed to consent to them.

Nursing staff clearly recorded consent in the patients' records.

Nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards, training compliance was demonstrated at 100%.

Nursing staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Nursing staff could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards.

Please refer to the Consent, Mental Capacity Act and Deprivation of Liberty Safeguards section of the surgery core service report.

Are Outpatients caring?

Good

Compassionate care

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

Nursing staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

We saw evidence of staff introducing themselves to patients using their full name and explaining their role in the public waiting areas and taking to them in an informal way whilst walking to the consultation rooms.

All the patients we spoke with said staff treated them well and with kindness.

Nursing staff followed policy to keep patient care and treatment confidential.

Good

Outpatients

Nursing staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude.

Nursing staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Nursing staff told us patients were informed about the chaperone service and a female or male nurse would be present if requested by the patient at a consultation or during a procedure. The presence of a chaperone was recorded in the patient notes.

Blood tests were carried out discreetly in consultation rooms if required following a consultation.

In the October 2021 patient satisfaction survey, we reviewed there were many positive comments from patients about outpatient staff, however, there were no outpatient departmental patient satisfaction figures which meant the department could not benchmark their own performance.

Please refer to the compassionate care section of the surgery core service report.

Emotional support

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

Nursing staff gave patients and those close to them help, emotional support and advice when they needed it.

Nursing staff undertook local training delivered by a consultant on breaking bad news.

One of the specialist consultants had delivered internal training for staff on how to break news of a life changing diagnosis and how to provide emotional support. Nursing staff we spoke with told us they had found this very useful.

Nursing staff told us how they would signpost patients, relatives or carers to specialist support services following delivery of bad news or a life changing prognosis.

Nursing staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them.

The patients we spoke with told us they had been involved in decisions about their treatment.

The patients we spoke us told us they had been given discharge information which they fully understood including contact numbers to ring if they had any concerns about their recovery. If a patient had concerns on a Sunday, when the hospital was closed, calls are directed to the ward, patient would be spoken to by Ward Nurse and RMO and consultant as necessary and asked to return to hospital if needed, if deemed an emergency patient would be directed to local A&E or a 999 call would be made.

Please refer to the emotional support section of the surgery core service report.

Good

Outpatients

Understanding and involvement of patients and those close to them

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

Nursing staff made sure patients and those close to them understood their care and treatment.

Nursing staff talked with patients, families and carers in a way they could understand.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Nursing staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service.

Patients we spoke with told us they had all been informed about their care and treatment and fully understood the risks and benefits. They had all been able to ask questions which were responded to in a way which could be understood.

Please refer to the Understanding and involvement of patients and those close to them section of the surgery core service report.

Are Outpatients responsive?

Good

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the changing needs of the local population.

The service worked in partnership with the local NHS trust to accept NHS funded patients to address waiting lists.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion.

Facilities and premises were appropriate for the services being delivered.

The hospital was clearly sign posted on local road signs and identifiable from the road through external signage. The hospital was on a bus route and had a large car park for staff and patients to use.

The entrance to the building, waiting area, corridors, consultation rooms and toilet facilities were suitable for wheelchair users.

Good

Outpatients

There was a ground floor unisex patient toilet.

The doors in the outpatient's department had signs indicating what they were used for and which consultant was using the room.

The reception area had a desk to book in patients and a separate office which staff used when making confidential phone calls so they could not be overheard.

There was a separate office for nursing staff to use. The door to the office could be closed to allow staff to have confidential discussions or make phone calls about patients.

The outpatient department appeared tidy, free of clutter with no equipment left in corridors.

Managers monitored and took action to minimise missed appointments.

There was no did not attend (DNA), report in the hospital patient management system, however, if a patient did not attend this was logged and followed up with correspondence and to reschedule where appropriate. There was no process for recording how many patients did not attend nor did they identify any themes or trends.

There was no formal process in place to monitor how long patients waited to be seen once booked in. We saw staff on the front reception desk taking note of the time when a patient checked in and monitored it accordingly for any prolonged delays so the patient could be kept updated.

Follow-up appointments were made by the reception desk booking team following receipt of information from consultants after their patient consultation.

Reception desk staff booked the appointment in accordance with the consultants' availability.

On inspection it was noted there were 32 follow up appointments needing to be booked in. Reception desk staff told us this was not an unusually high number and the appointments would be made by the next day when the consultant availability was released.

The consultation appointment dates were projected and booked six weeks in advance.

Unexpected outpatient consultation cancellations were logged within the hospital incident reporting system for review, and any repeated issues would be flagged with senior management for escalation and further action.

Please refer to the service delivery to meet the needs of local people section of the surgery core service report.

Meeting people's individual needs

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

Consultation rooms were not specifically designed to meet the needs of patients living with dementia.

Good

Outpatients

Appointment times could be extended due to additional needs.

Nursing staff understood and applied the policy on meeting the information and communication needs of patients living with a disability or sensory loss. Staff we spoke with could explain what communication aids they could use to communicate with patients. This included use of Perspex full face masks to enable patients to lip read.

Nursing staff explained they did have access to translation services and British Sign Language support for patients if required. The needs of the patients were identified during pre-assessment and the required support would attend the consultation. The pre-assessment meant there were no delays in providing patients with the support they required.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Please refer to the meeting people's individual needs section of the surgery core service report.

Access and flow

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

Managers made sure patients could access services when needed and received treatment within agreed timeframes based upon consultant availability.

There was no specific waiting list report for outpatients. All consultation requirements were reviewed weekly at a capacity meeting where any issues were identified and resolved.

Following the review of waiting list numbers at the weekly capacity meeting appointments were offered to those consultants with patients waiting to ensure clinical need was prioritised.

The service reviewed options for additional capacity to deal with any patient backlog. At the time of the inspection the provider had secured additional staffing in order to provide increased ophthalmology support for the NHS.

Managers worked to keep the number of cancelled appointments/treatments/minor operations to a minimum. This information was cross referenced with the referral to treatment (RTT) report weekly. Clinic allocations were also reviewed to ensure space was not underutilised. We saw very low numbers of appointments being cancelled.

When patients had their appointments/treatments/minor operations cancelled at the last minute, managers made sure they were rearranged as soon as possible. We saw examples of cancelled appointments being made within 24-72 hours.

Please refer to the access and flow section of the surgery core service report.

Learning from complaints and concerns

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

Good

Outpatients

In line with infection prevention control during COVID-19 the department could not display paper information. However, leaflets were stored in the offices and available to provide to patients including 'Your Opinion Matters' which included the website information to contact the complaints team directly with alternative information to complain via email or post.

Nursing staff understood the policy on complaints and knew how to handle them. Nursing staff told us they would try and resolve any complaints or patient issues immediately without using the formal complaint recording route.

The investigation of complaints and identification of themes was done at a provider corporate level and information fed back to all Nuffield sites.

The corporate complaints investigation findings were shared across all Nuffield sites regardless of where the complaint originated from. This meant wider learning was achieved.

There were no complaints relating to the hospital outpatient's department.

Nursing staff told us managers shared feedback from complaints with staff and learning was used to improve the service. Staff we spoke with told us this was done through emails or documents which had to be signed to confirm the information had been read.

Managers told us should there be any patient complaints following a cancellation of a consultation a feedback form would be completed and escalated with the complaints lead so this was recorded and patterns or themes identified.

Please refer to the Learning from complaints and concerns section of the surgery core service report.

Are Outpatients well-led?

Good

Leadership

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

The manager in the outpatient's department we spoke with had the skills, knowledge and experience for their role.

Nursing staff we spoke with told us leaders were visible and approachable.

Staff we spoke with thought the main challenge was the actual building which was small and old.

Please refer to the of the leadership section of surgery core service report.

Vision and Strategy

Good

Outpatients

The service was not able to articulate what vision it wanted to achieve nor the strategy to turn it into action.

The provider's value framework was listed as being; connected, aspirational, responsive and ethical. Nursing staff we spoke with could explain what the values meant and what their role in achieving them.

The service was able to support the wider health economy by taking referrals from local NHS hospitals to reduce NHS waiting lists for minor outpatient procedures.

The nursing staff we spoke with were clear about their roles and responsibilities and they all knew who their line manager was.

Please refer to the of the vision and strategy section of the surgery core service report.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service 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 provided opportunities for career development through the appraisal system which identified courses which staff could complete. Nursing staff we spoke to told us they had been given the opportunity to undertake academic studies which were funded by the hospital.

Nursing staff we spoke with felt positive and proud to work in the organisation.

Nursing staff told us there was a very positive culture with supportive managers. They spoke of feeling like a valued member of the team which all worked well together supporting each other.

All the nursing staff we spoke with told us they felt comfortable reporting issues to managers. This could be done through the whistleblowing process or through the freedom to speak up guardian.

A positivity board was used where staff could add positive thoughts which could be shared with others to boost morale.

Nursing staff told us they worked collaboratively with other departments in the hospital such a pathology, diagnostics and physiotherapy to share responsibility for positive patient outcomes.

Lessons learned from incidents were shared with nursing staff.

Managers told us if staff had been involved in an incident with an aggressive patient support would be provided by a department head. The incident would also be logged in the incident reporting system for review and any shared learning.

The hospital had not recorded any such incidents.

Patients told us that positive and negative feedback was encouraged and they felt able to provide both without fear.

Good

Outpatients

Governance

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

At a departmental level nursing staff took part in a weekly morning meeting to discuss the consultation appointments for the forthcoming week in addition to any minor procedures which were booked to be carried out.

Nursing staff told us they provided information to the outpatient manager to take to MDT meetings.

The outpatient unit manager took part in Clinical Governance meetings where incidents, staffing, risks and the risk register was discussed.

The outpatient unit manager took part in the Clinical effectiveness meeting each month where there was discussion about feedback, learning, and Root Cause Analysis.

We saw evidence that due to the COVID-19 pandemic and associated restrictions the way teams met and communicated had to be adapted.

The unit manager had daily visits to all the teams and communicated virtually with them to ensure communication was maintained with all staff.

Managers and staff, we spoke with told us they all felt this had been an effective method to maintain communication whilst allowing the maximum amount of time for patient focused care.

The Clinical Governance Committee Minutes of meetings held on 15 September, 13 October and 17 November 2021 were reviewed. The outpatient's department was represented at these meetings which had a set agenda with actions and owners.

We reviewed a copy of the October 2021 Quality report which has been taken to the executive board in November 2021. The report had been complied by the Head of Clinical Quality and Professional Practice. The report provided a corporate overview of key areas of performance.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. Equipment in the outpatient's department was overseen by an external contractor. This included servicing, repair and replacement.

The outpatients department did not produce key performance indicator (KPI) reports but did use key areas of performance data to improve services.

Please refer to the of the Management of risk, issues and performance section of the surgery core service report.

Information Management

Good

Outpatients

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

The hospital produced detailed reports and minutes for the weekly meetings, however, the individual PRF`s were not included as they contained specific patient information.

Staff were aware of their responsibilities in relation to data protection, and information governance formed part of their mandatory training.

We saw evidence patient information was stored securely.

Please refer to the of the information management section of the surgery core service report.

Engagement

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

During inspection we reviewed the patient satisfaction survey for October 2021.

There were positive comments about how the patients enquires were dealt with, information provided, overall pre-assessment, feeling safe in relation to COVID-19 precautions, ease of understanding information, understanding shown by the consultant and how the consultant explained matters.

We saw evidence of staff engagement and feedback in relation to hospital improvement plan. It was clear from the document the views from staff had been taken account of in completing the actions.

Please refer to the of the engagement section of the surgery core service report.