Parkside Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

Parkside Hospital is operated by Aspen Healthcare Limited. A team of nurses, healthcare assistants and administrative staff are responsible for coordinating the delivery of outpatient clinics. Clinics are led by surgeons, doctors, nurses and allied health professionals (AHP).

The hospital has 75 beds. Facilities include operating theatres, a five-bedded high dependency unit (critical care unit), and X-ray, outpatient and diagnostic facilities.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced of the service inspection on 17 -18 September 2019, 15 – 16 October 2019 and 4 – 5 December 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's

Summary of findings

needs, and well-led? Where we have a legal duty to do so, we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

Services we rate

Our rating of this service stayed the same. We rated it as Good overall.

- 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 understood how to protect patients from abuse and the hospital worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care. Managers appraised staff's work performance annually and checked to make sure staff had the right qualifications and professional registration for their roles. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.
- Patients could access services and appointments in a way and a time that suited them. The service used technology innovatively to ensure patients had timely access to all the diagnostic tests before their scheduled appointment.
- 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. However, in the surgical ward, staff did not always keep sufficiently detailed records of patients' care and treatment.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared learning with the whole team and the wider service.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other hospitals to learn from them.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- 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.
- Staff worked hard to make the patient experience as pleasant as possible. Staff recognised and responded to the holistic needs of patients from their first referral before admission to checks on their wellbeing after they were discharged from the hospital. They understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Staff identified and quickly acted upon patients at risk of deterioration. Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. The service used systems and processes to safely prescribe, administer, record and store medicines.
- Staff were professional, friendly and polite when addressing patients or their relatives. They were willing to help and demonstrated commitment to patient-centred approach. It was easy for people to give feedback and raise concerns about care received.
- Staff supported patients to make informed decisions about their care and treatment. The service was inclusive and took account of patients' individual needs and preferences.
- 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 standards.

However:

Summary of findings

- Managers did not have a systematic approach to regularly review and adjust staffing levels and skill mix. They did not consistently monitor acuity of patients and adjusted staffing level to allow the same level of service regardless of patient's acuity and numbers.
- The service did not always ensure staff completed mandatory training.

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

Dr Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care (including older people's care)	Good	Medical care services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was safe, effective, caring and responsive. Staffing was managed jointly with medical care.
Surgery	Good	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. Staffing was managed jointly with medical care. We rated this service as good because it was effective, caring, responsive and well-led, although it was rated as requires improvement for safe.
Critical care	Good	Critical care services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section of the report. The hospital has a five-bed high dependency unit providing level 1 and 2 care. We rated this service as good because it was safe, effective, caring, responsive and well-led.
Services for children & young people	Good	Children and young people's services was a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was safe, effective, caring and responsive and well led.
Outpatients	Good	We rated outpatients good because it was safe, caring, responsive and well led. We inspected but did not rate effective. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.

Summary of findings

Diagnostic imaging	Good 	Diagnostic imaging services was one of the key clinical services at the hospital. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was safe, effective, caring and responsive and well-led.

Summary of findings

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Services we looked at

Medical care (including older people's care); Surgery; Critical care; Services for children & young people; Outpatients; Diagnostic imaging.

Summary of this inspection

Background to Parkside Hospital

Parkside Hospital is operated by Aspen Healthcare Limited. It is a private hospital in London. The hospital primarily serves a national patient population. It also accepts patient referrals from overseas patients.

Parkside Hospital is a purpose-built in-patient facility situated in Wimbledon and opened in 1983. It is owned by NMC Healthcare, who purchased Aspen Healthcare Limited (the UK trading arm of NMC Healthcare, a UAE based healthcare business) in September 2018. An expansion and refurbishment in the day surgery unit and endoscopy was underway at the time of inspection, as part of a planned programme to achieve the Joint Advisory Group accreditation and improve the services offered to patients.

The current registered manager has been in post since January 2017.

Our inspection team

The inspection team comprised of one CQC lead inspector, three other CQC inspectors, specialist advisors in nursing, surgery and pharmacist inspector. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection for London.

Information about Parkside Hospital

Parkside Hospital provides private medical and surgical services from departments within the hospital site in Wimbledon. The hospital has 75 beds. Facilities include four operating theatres, 11 day-care beds, 59 ensuite rooms out of which 42 were dedicated to surgical patients, a five-bedded level two care high dependency unit (HDU), outpatient and diagnostic facilities.

The hospital provides medical, surgical and outpatient appointments for multiple specialties. Between April 2018 to March 2019, the service had seen 37,951 first attendances and 49,196 follow up appointments. Patients either paid for appointments themselves or claimed on medical insurance. Less than 5% of outpatient appointments were funded by the National Health Service.

The hospital provides a range of services to patients who are self-funded, use private medical insurance. Services include general surgery, orthopaedics, cosmetic surgery, ophthalmology, general medicine, oncology, dermatology, physiotherapy and diagnostic imaging, ophthalmology, endoscopy and orthopaedic services.

Services available to NHS funded patients through choose and book were gender re-assignment, orthopaedic, ENT, general surgery, pain management.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection.

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

- Treatment of disease, disorder and injury
- Surgical procedures
- Diagnostics and screening procedures

During the inspection, we visited the wards, outpatients' department, diagnostic imaging department, pharmacy, theatre, high dependency unit, the endoscopy unit, and the day care unit. We spoke with 25 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 15 patients and five relatives. During our inspection, we reviewed 12 sets of patient records.

Summary of this inspection

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected four times, and the most recent inspection took place in May 2016, which found that the hospital was meeting all standards of quality and safety it was inspected against.

Track record on safety from March 2018 to February 2019:

- No reported never events.
- No reported incidences of healthcare acquired Meticillin resistant staphylococci aureus (MRSA).
- No reported incidences of healthcare acquired Meticillin-sensitive staphylococcus aureus (MSSA).
- No reported incidences of healthcare acquired clostridium difficile.
- No reported incidences of healthcare acquired E-Coli.

Services accredited by a national body:

- Sit & SeeTM Observational audit of care and compassion with Aspen being the 1st private hospital to implement this quality audit.
- Macmillan Quality Environmental Mark (MQEM) – Information and Day Services.
- Patient Led Assessment of the Care Environment (PLACE) – Assessment and published results.
- Pathology accredited laboratory by United Kingdom Accreditation Service (UKAS)
- International Organization for Standardization (ISO) accredited Sterile Services.
- The Association for Perioperative Practice (AfPP) accreditation.

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Interpreting services
- Grounds Maintenance
- Laser protection service
- Laundry
- Maintenance of medical equipment
- RMO provision

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

Are services safe?

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

- Staff were aware of how to report incidents and learning was shared with staff during morning huddle and at team meetings.
- All areas visited were visibly clean and tidy. Staff had access to personal protective equipment and hand sanitiser gel dispensers were available in all areas we visited.
- The environment was suitable for the services provided. Staff had access to a wide range of specialist equipment and equipment were well maintained.
- Resuscitation trolleys were available at all areas and departments of the hospital we visited and had been checked daily.
- There were effective systems in place for safeguarding vulnerable adults and children.
- Patient records were legible, comprehensive, signed and dated with appropriate assessments completed.
- Medicines were stored safely and securely in a locked cupboard.

Are services effective?

Good

Are services effective?

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

- The service provided care and treatment based on national guidance and evidence of its effectiveness. New guidance was widely circulated and acted on.
- Staff gave patients enough food and drink to meet their needs and improve their health. The service adjusted for patients' religious, cultural and other preferences.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them using appropriate national and a comprehensive local audit plan.
- Systems and processes were in place to ensure that clinical staff had their competencies regularly assessed through appraisals and one to one meeting with their supervisors and managers.

Summary of this inspection

- Staff had a good understanding of consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). All staff had undergone appropriate training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Are services caring?

Good

Are services caring?

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

- All patients we spoke with told us that staff had treated them well and felt that they had received timely and informative care and treatment.
- Staff provided emotional support to patients to minimise their distress. We saw staff interacting with patients in a supportive manner by offering sympathy and reassurance.
- The service had measures in place to protect the privacy and dignity of patients and we observed that chaperones were available to patients who needed them.
- Staff provided emotional support to patients and gave examples of when this had been necessary.
- Signage in the departments and the patient information provided also helped to ensure that patients and their families understood relevant information about their care and their visit to the hospital.
- Patient satisfaction surveys were positive and positive feedback from patients was consistent in all areas of the service.
- There were monthly patient group meetings, which provided an opportunity for patients to talk to others who had had similar experiences.

Are services responsive?

Good

Are services responsive?

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

- The service planned and provided services in a way that met the range of needs of patients accessing the outpatient services.
- The service took account of patients' individual needs, it had a proactive approach to understanding individual needs, was accessible and promoted equality.
- Patients could access the service in a way and at a time that suited them. There were no waiting times for appointments and patients were booked to suit their individual needs.

Summary of this inspection

- Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were better than the national average.
- Reception areas were equipped with television and there was a range of information leaflets available to patients on a wide range of topics.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously.
- The service had a complaints policy. An appropriate system was in place to log and investigate complaints and we saw complaints about the wider hospital being discussed in staff meetings to share learning. The registered manager investigated complaints and shared outcomes with all staff.

Are services well-led?

Good

Are services well-led?

Our rating of well-led improved. We rated it as Good because:

- Managers had the right qualifications and skills to run a service, providing high-quality sustainable care.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action and all staff we spoke with were aware of the hospital's vision.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- Appropriate governance systems were in place and most staff spoke highly of their supervisors, managers and colleagues.
- The service systematically improved service quality and safeguarded high standards of care by creating an environment for good clinical care to flourish.
- The service had good systems to identify risks, plan to eliminate or reduce them, and to cope with both the expected and unexpected. The management team had oversight of the risks within the services and had plans to mitigate them.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with patients, their families and local organisations to plan and manage appropriate services through surveys and feedback forms. There was evidence of good staff engagement and changes being made as a result.
- The provider had implemented several innovative services and developed these to meet patient's needs. Staff had contributed to developing and improving services.

Good

Medical care (including older people's care)

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

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

Good

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

Mandatory training

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

Nursing staff received and kept up-to-date with their mandatory training. The hospital analysed what skills were required to perform individual tasks and how frequent various mandatory training was to be delivered to individual staff. The analysis took into account job roles and prescribed if training was to be delivered using e-learning resources, face to face or if skills were to be assessed 'on the job'.

The mandatory training was comprehensive and met the needs of patients and staff. We saw that most staff had completed their mandatory training. Two members of staff were yet to fully complete their yearly training; however, we saw that these staff had been booked onto future training sessions.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Managers monitored mandatory training and alerted staff when they needed to update their training. Staff could access training online and face to face training was available for basic and intermediate life support, manual handling, fire awareness and aseptic technique. Staff we spoke with had received training in sepsis management, including neutropenic sepsis.

The hospital did not provide records for training completion amongst its medical staff. However, we were told that the resident medical officer's (RMOs) completed their training through their agency.

Safeguarding

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

Staff were required to complete safeguarding level 1 training for adults and children every three years. Level 2 training was provided to all clinical staff. Safeguarding children level 3 was provided to staff who were the safeguarding leads in their speciality, in line with the safeguarding children-roles and competences for healthcare staff guidance. The training provided also raised awareness of issues related to female genital mutilation (FGM).

Staff we spoke with knew how to raise any safeguarding concerns. They were able to describe different types of safeguarding concerns and could explain how they would respond if they witnessed or suspected abuse. Staff knew who the safeguarding lead was, and who they could raise concerns with in the lead's absence.

Staff told us that cancer patients had alert cards where required, such as for chemotherapy, so that staff at the hospital as well as other facilities knew how to keep the patients safe.

Good

Medical care (including older people's care)

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.

Both the ward area and endoscopy were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We saw that weekly and monthly cleaning schedules were used, and that these were fully completed. However, we saw that 'I am Clean' stickers were not used on all pieces of equipment on the medical ward. This meant that inspectors could not be assured when the equipment had last been cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE). All patients on the ward were placed in a single occupancy room to prevent the spread of infection for example, infectious diarrhoea, Meticillin resistant staphylococci aureus (MRSA) , tuberculosis (TB) and chickenpox amongst others. This also protected patients with reduced immunity from catching an infection.

There was sufficient access to hand gel dispensers, handwashing, and drying facilities. Hand washing basins had a sufficient supply of soap and paper towels. Services displayed signage prompting people to wash their hands and gave guidance on good hand washing practice. Personal protective equipment such as disposable gloves and aprons were readily available in all areas.

Staff followed the hospital infection prevention and control policy, they were bare below the elbow and used hand sanitisers appropriately. We saw all staff both clinical and non-clinical, adhering to good hand hygiene policy. We saw that new admissions were screened for infections such as MRSA, MASSA, c-difficile and e-coli. We saw endoscopy had appropriate decontamination processes in place.

Staff disposed of clinical waste safely. Clinical and domestic waste bins were available and clearly marked for appropriate disposal. We noticed information explaining waste segregation procedures and waste segregation instructions. We saw that there were separate bins that were clearly labelled for cytotoxic waste.

We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw that there were separate sharps bins available for cytotoxic waste. We also saw that there was a cytotoxic spillage kit available for staff to use in the event of a cytotoxic spillage.

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 we saw that staff responded quickly when called. The design of the environment followed national guidance. Overall the areas we visited were in a good state of repair.

The endoscopy area was currently undergoing a rebuild to make it a JAG (joint advisory group) accredited site. This included building new pre and post procedure areas, as well as a separate entrance so that patients did not have to go through the main hospital. The hospital told us that the building works were due to be completed by the end of October 2019. We saw that the building works were adjusted when patients were undergoing procedures, so that there was no excessive or disturbing noises.

Staff carried out daily safety checks of specialist equipment. Equipment we checked had servicing and electrical safety stickers on indicating it was safe to use for the designated purpose. Staff told us they felt the equipment used by them was modern and well maintained.

Resuscitation equipment stored on the resuscitation trolley was readily available and easily accessible. The hospital had a system to ensure it was checked regularly, fully stocked, and ready for use.

The service had suitable facilities to meet the needs of patients' families. There was a family/day room available for patients and families to use in the event that they didn't want to stay in their room.

The service had enough suitable equipment to help them to safely care for patients. However, we saw that one of the store rooms used to store equipment was very small, overcrowded and cluttered, meaning it could be difficult for staff to locate equipment when needed.

Good

Medical care (including older people's care)

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.

Qualified staff used the national early warning score two (NEWS2), a nationally recognised tool to identify deteriorating patients and escalated them appropriately. We saw that NEWS 2 scores were fully and accurately completed, and regularly reviewed. A NEWS 2 completion audit carried out by the hospital on a sample of ten records in August 2019 indicated good compliance with the required standard. Staff were provided with NEWS 2 and sepsis specific training. We saw staff also used a sepsis care bundle for identifying and managing patients with sepsis, including patients with neutropenic sepsis.

The endoscopy unit had a comprehensive care plan which included the hospital's own safety checklist and the World Health Organisation (WHO) surgical safety checklist on admission to the unit. However, the unit performed only three (sign in, time out and sign out) out of the five steps of the WHO surgical safety checklist, which included team brief, sign in, time out, sign out and debrief, and this was not in line with the guidance issued by the World Health Organisation on completion of the WHO safety checklist. The complete WHO surgical safety checklist did not appear to be well embedded into the practice of the endoscopy unit.

During the inspection, we reviewed six sets of notes. We saw that risk assessments for venous thromboembolism (VTE), pressure sores, and falls and were regularly completed. However, in two records, staff had not completed nutritional risk scores and records were not sufficiently detailed to allow safe management of those risks. The hospital carried out a quality audit to ensure staff completed VTE assessments correctly and it noted overall good compliance with the procedure.

Staff shared key information to keep patients safe when handing over their care to others. We saw shift changes and handovers included all necessary key information to keep patients safe. There was adequate medical cover and specialist availability for on-going treatment and care.

Qualified staff nurses accompanied patients who had undergone an endoscopy procedure back to the recovery area for further assessment, care and supervision. If a patient became unwell, they were taken to a ward and supervised until their condition was stabilised and ready to be discharged. Patients pathways were in place for the referral and transfer of patients to local NHS hospitals in an emergency if this was required. Patients were given out the hospitals' of hour's telephone numbers on discharge from the endoscopy unit, in case they became unwell after their endoscopy procedure.

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.

The hospital employed 68 whole time equivalent (wte) nursing staff on its inpatient wards and within theatres. We saw that the medical ward had a vacancy rate of less than one full time nurse. During our inspection, we saw that the ward was adequately staffed, had one ward manager, two registered nurses, and one health care assistant caring for six patients. This was a good nurse to patient ratio. We saw that there was at least one chemotherapy trained nurse on duty per shift.

We saw that the ward very rarely used agency nurses, and when they did, they ensured they were chemotherapy trained nurses. We saw a mix of shift patterns with some staff doing early and late shifts, and others doing long shifts. We were told that the ward manager could adjust the staffing to meet the number of patients on the ward, and that when the ward was at capacity of 15 patients, the ward would have four registered nurses and one health care assistant on duty, as well as the ward manager. We saw that the endoscopy unit was fully staffed and could adjust its staffing according to caseload.

The hospital reported staff sickness rate at 3.6% and turnover rate 2.1% in 2018/2019. This was similar to other sites managed by the provider. The rate of agency staff use was low at 1.6%.

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.

Good

Medical care (including older people's care)

The hospital employed four resident medical officers (RMOs), so one was always available on site. Each doctor worked a 12-hours shift, split between day and night duty. The RMOs worked a shift pattern of seven days on, seven days off, which allowed them time for rest and recuperation. If a doctor was unable to complete their shift or called in unwell, a contract supplier ensured a cover doctor was arranged, however, this did not occur often. RMOs told us that in the event they had not been able to have adequate rest breaks, a cover doctor was arranged. However doctors told us that they were able to have adequate breaks and had not needed to arrange extra cover.

Consultants provided out of hours support and were available to staff to respond to queries related to individual patients. There were designated on-call rotas that specified who was to provide support for radiology, pathology, pharmacy, physiotherapy or who was the on-call manager.

Records

Staff kept detailed records of patients' care and treatment. Records were not always 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. Patient records were multi-professional clinical notes, which included those from physiotherapists, occupational therapists, dietician and nurse specialists. Patient records were paper based, meaning notes were handwritten.

During the inspection, we reviewed six sets of patient notes. We found that some entries from the medical staff were difficult to read, and not clearly labelled as an entry from a medical professional. This meant staff could not always clearly read the medical plans for the patients. However, we saw that medical plans were also verbally discussed with the ward staff.

We saw that risk assessments were not always completed. Out of the six records we reviewed, we saw that two patients did not have a malnutrition risk assessment completed (MUST score). We saw that two patients who had intravenous devices had not had regular venous infusion phlebitis (VIP) scores completed. This meant inspectors could not be assured that staff were monitoring intravenous devices for signs of infection, pain, or phlebitis, including during the use of cytotoxic medication.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We saw that staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We saw the ward was visited by a dedicated chemotherapy trained pharmacist twice a day. We saw that that cytotoxic medicines were stored separately, and that patients were educated as to their handling and storage when being discharged from hospital. We saw that only staff trained in administering cytotoxic medication were able to administer chemotherapy.

Staff mostly stored and managed medicines and prescribing documents in line with the provider's policy. We saw that medicines were stored securely in locked cupboards in the patient's rooms. We saw that stock medication was securely stored in locked cupboards within the locked treatment room. Inspectors found that controlled drugs (CDs) were checked on a daily basis and correctly documented in the CD register, with access to them restricted to authorised staff. We saw separate refrigerators in the treatment room for general medications and cytotoxic medications. This meant general medicines could not be contaminated by cytotoxic medication. However, inspectors saw that the fridge temperatures were not checked on a daily basis, as per hospital policy. This meant that inspectors could not be assured that medicines were being stored at safe temperatures.

We saw resuscitation trolleys were located at an easily accessible and well ventilated area, away from radiators. The medicines contained within, consumables, and cylinders were in date and records of expiry dates were also kept in the pharmacy as a backup check.

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. They used an electronic incident recording system that allowed to capture incidents, track any actions taken in response and provide relevant staff with feedback.

Good

Medical care (including older people's care)

When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

The service did not report any never events during the past 12 months prior the inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Incident reporting culture was strong, and feedback was provided to staff that reported incidents. None of the staff we spoke with mentioned any concerns about patient's safety. Significant events were also highlighted in the staff handovers and operational huddles.

Staff we spoke with felt there was a learning culture and that they could raise issues without worrying about repercussions.

The Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service had a policy which described the Duty of candour process. Staff we spoke to, understood the Duty of candour requirement and its implication to clinical practice. Staff could give examples of when duty of candour had been applied on both the medical ward and the endoscopy unit.

Safety Thermometer (or equivalent)

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors. Although the service was not required to report under the NHS Safety Thermometer programme they collected relevant information and used it for measuring, monitoring and analysing patient harms and 'harm free' care.

Reports that monitored falls indicated there were 10 patients slips, falls and trips in 2018/2019, two of those resulted in harm. The hospital reported that no patient had developed pressure ulcers. During the same period, it was reported that only 80% of patients had VTE assessment undertaken within 24 hours of admission.

Records indicated that urinary catheters care plans were not always fully completed. Urinary tract infections related to urinary catheters were not regularly reported through quality governance reporting system.

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

Good

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The hospital used a combination of National Institute for Health and Care Excellence (NICE) and Royal College guidelines to guide the treatment they provided. For example, the most recent version of the national early warning score system (NEWS2) was used to assess and respond to any changes in a patient's condition.

We saw the medical ward used NICE guidelines for administration of chemotherapy. We saw that up to date clinical guidelines were discussed at acute oncology meetings. This was attended by the cancer lead nurse and ensured collaborative working within oncology teams in the hospital.

Staff told us that clinical guidelines and policies were available on the hospital intranet. We reviewed a sample of the hospital policies and found that they were compliant with current guidance and best practice. We noted all policies and guidelines we reviewed were all in date.

Nutrition and hydration

Good

Medical care (including older people's care)

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service 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. Specialist support from staff such as dieticians and speech and language were available for patients who needed it. We saw patients were regularly reviewed by the dietician and had dietary supplements and specific diets prescribed as needed.

All patients had a choice of meal for breakfast, lunch and dinner, and were offered additional snacks in the mornings and afternoons. They could ask for meals at other times, from a more limited range of options, and change their orders if they preferred. We saw that patients had their meals adjusted to allow for religious beliefs and cultural needs. Patients with a reduced appetite were able to order food from a 'lighter bites' menu. Staff told us that chefs would visit the ward in order to meet patient's food preferences and needs such as those with allergies, coeliac disease, lactose intolerant, as well as religious diets.

We saw that staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool called mulnutrion universal screening tool (MUST) to monitor patients at risk of malnutrition. However, we saw that these were not always completed for each patient.

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. Assessments of patient's pain were included in all routine sets of observations. As part of the 'intentional rounding' process, where staff attend patients at set intervals to check a range of patient related clinical and vital signs, staff ensured that patients were comfortable, their pain well managed and recorded this in their medical notes. We saw that staff used a non-verbal pain chart to asses the pain of a patient who did not speak English.

Medicines, including controlled drugs, were available to relieve pain if patients required them. Oncology patients usually brought their own medications when attending the hospital, but the pharmacy was able to provide drugs if prescribed. The nursing staff told us they sought advice from the clinical nurse specialists for oncology and the palliative care consultant for support and advice on pain management when looking after more complex patients.

Most patients we spoke with told us they received pain relief soon after requesting it. One patient told us that staff did not always give them pain relief when requested, and they were made to wait, which left them in pain. Staff told us that this patient was receiving pain relief by an infusion, and had also had top up medication for breakthrough pain, but they were still experiencing some pain. The patient was reviewed by medical staff and their pain relief increased, which helped alleviate their pain.

Patient outcomes

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

On our last inspection we saw that the endoscopy service did not have Joint Advisory Group (JAG) accreditation. However work was underway to upgrade the endoscopy service to meet the JAG accreditation. During this inspection, we saw that the work was nearing completion and was due to be completed by the end of October 2019. Management told us the hospital was aiming to be assessed and accredited under the JAG clinical accreditation scheme by the end of November 2019. Inspectors were able to see the work that had been undertaken, as well as the plans for the work that was nearing completion.

There was an audit schedule in progress across the oncology and end of life care services we inspected. This included consent, records, pain, NEWS2, complaints, privacy and dignity, consultant visits, consultant notes, intentional rounding, safeguarding, resuscitation, privacy and dignity, transfusion compliance, and information governance.

Good

Medical care (including older people's care)

We saw that the service also audited their achievement in end of life care. All expected deaths were discussed at monthly expected death review meeting, to learn where improvement can be made, and to praise when things went well.

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.

The hospital had an induction policy which outlined that new starters in the department were supported to complete their induction program, and also being familiar with their working environment, only using equipment that they were competent to use and identifying their learning needs. Trained nurses on the medical ward also had competency book they were required to complete, which included such things as competencies relevant to cytotoxic medications.

The hospital reported 78% of contracted nursing, healthcare assistants and allied health professionals staff were appraised in 2018/2019 and all the medical staff. Managers showed us that in medicine, only two members of staff were yet to have their appraisal completed. We saw that both had dates for their appraisals, and these were within the 12 month appraisal period.

During the same period only 50% of medical staff underwent practising privileges review which was required every two years.

The director of nursing and clinical services monitored the nursing revalidation process and staff were supported in collating their evidence for revalidation. Revalidation is a new process since 2016 where nurses and midwives need to demonstrate to the Nursing and Midwifery Council that they can practice safely and effectively.

Any concerns related to the consultants around their competency was dealt with via the medical advisory (MAC) guidelines. Ongoing compliance with practising privileges was monitored monthly by the MAC.

Multidisciplinary working

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

Throughout the inspection we saw evidence of good multidisciplinary working in all areas. We observed positive interaction and respectful communication between professionals. We saw that information was appropriately shared with community teams such as GPs, district nurses, community oncology team and hospices.

Regular consultant led multidisciplinary team meetings were held to discuss patients treatment. We were told by managers that nursing staff, allied health professionals and managers attended these meetings. Staff told us consultants were approachable and always willing to give help and advice. The hospital also had a morning huddle handover meeting to discuss any concerns, unwell patients, incidents, as well as admissions for the day.

Seven-day services

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

It included access to a high dependency unit and resident medical officer, as well as on-call support provided by the named consultant.

There were designated on-call rotas that specified who was to provide support for radiology, pathology, pharmacy, physiotherapy or who was the on-call manager.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units.

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

Although we did not see any patient leaflets on the medical ward, staff showed us pre-printed patient information leaflets, for example blood transfusion that were stored in the multidisciplinary room. Staff told us they could access patient leaflets from the intranet, and would print them out as required.

Good

Medical care (including older people's care)

Endoscopy had patient information leaflets that they gave each patient after their endoscopic procedure, that provided information about aftercare.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff had received training in Mental Capacity Act 2005 (MCA) and consent. Staff were able to give clear explanations of their roles and responsibilities under the Mental Capacity Act 2005 (MCA) regarding mental capacity assessments. The training took account of young adults and children. All staff we spoke to could tell us where they could seek support if needed and identified the safeguarding leads by name.

We saw that consent to treatment was clearly documented in the patient notes, and observed all staff gaining verbal consent from patients before undertaking any interactions and interventions.

Staff protected the rights of patients' subject to the Mental Health Act and followed the Code of Practice. We saw that during shift handover, and at the daily safety meeting, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

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

Good

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

Compassionate care

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

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. Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. The family of one patient who did not speak English and was of a different culture told us that staff ensured the patient's religious needs were being met, by providing the correct religious diet and allowing time for prayer.

Staff were professional, friendly and polite when addressing patients or their relatives. They were willing to help and demonstrated commitment to patients centred approach.

Patients and relatives, we spoke with said they were extremely happy with the support offered and found staff very approachable, responsive, and took the time to care. One patient told us that they kept coming back to the hospital because they couldn't fault the care they had received each time.

The hospital undertook a regular inpatients survey and analysed it quarterly. The analysis prepared by the hospital at the beginning of 2019 indicated that patients' feedback was overwhelmingly positive. Patients were encouraged to comment on their experience of the quality of care, whether they felt treated with respect and dignity, if they found nursing and medical staff professional amongst other areas. We noted that the response rate was at 50% and the hospital received between 833 and 1218 response each quarter.

Emotional support

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

Staff treated and involved patients and their relatives as partners in assessing and meeting their emotional needs, which was understood as being crucial in the patient's care.

Staff understood the impact that patient's care, treatment and condition had on their wellbeing. Staff we spoke with

stressed the importance of treating patients as individuals. We observed that staff spoke with patients compassionately to put them at ease and minimise their distress.

Staff told us of the pastoral care that was available for the patients on the medical ward, and knew how to contact the different services both within and out of hours.

Patients and relatives commented that they had been well supported emotionally by staff. For example, patients were referred to counselling services and specialist nurses at an NHS trust if needed. A quiet room was available to discuss bad news with patients and relatives if this was required.

Patients undergoing chemotherapy also had alert cards to carry. We were told by the nursing staff that patients were routinely contacted 48hrs after they had been discharged for further advise and support and were also advised to contact the ward if they thought they had an infection.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment. We observed good rapport between staff and patients and staff displayed good listening skills.

Patients we spoke with told us that staff kept them informed about their care. They were involved in any decision making about their treatment, and felt that they could ask questions, and were listened to at all times. All patients we spoke with told us they have been provided with relevant information, both verbal and written, to make an informed decision about their care and treatment. We were told that the staff involved the patients families and carers as much as the patients and families wanted them to be involved.

During our inspection, we observed staff talking with patients, families and carers in a way they could understand, using communication aids where necessary. For example, we saw one patient who did not speak English communicated with using signals and gestures, as well as involving the family to interpret. Staff told us that they could arrange interpreters if required.

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

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

Good

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

Service delivery to meet the needs of local people

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

The medical ward was located on the third floor of the main hospital, and all patients' rooms were ensuite with a wall mounted television in each room. We saw examples of usual visiting hours being varied to accommodate the needs of the patients and visitors. For example, we saw that one family was allowed to stay with a patient 24 hours a day, as the patient did not speak or understand any English. This meant that staff were able to communicate effectively to the patient through the family if required, and the patient could also make their needs known through the family. The family told us that this made the situation much less stressful for both the patient and themselves.

Staff told us that in the event of a patient being extremely unwell or terminal, relatives were encouraged to stay around the clock if they wished. Staff told us that relatives were provided with a free meal when staying with their sick relatives.

Managers ensured that patients who did not attend appointments were followed up.

Meeting people's individual needs

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

We saw that the hospital was part of the local cancer network. This meant that they regularly met with leaders from local NHS trusts, private hospitals, hospices, and

social health organisations. This meant that patient's using different services were known to a local central organisation, and treatment was co-ordinated locally amongst the providers.

Inspectors were shown that advanced planning had been put in place for all patients in their notes. Advanced care planning is a process that enables individuals to make plans about their future health care. Patients we spoke with confirmed that advanced care planning was discussed with them.

During the inspection we did not see any patients who were receiving end of life care, however staff showed us the documentation they used for end of life care. The documents showed a very individualised approach to end of life care, that took individual patients care needs, pastoral needs, and family needs into account.

Ward staff had support and advise from the senior nurse for people living with dementia and those with learning disability. The ward had dementia champions, and staff we spoke with told us how they would seek support for patients with learning disabilities.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us that translation services were available face to face and via a phone link system for patients whose first language was not English.

Patients were given a choice of food and drink to meet their cultural and religious preferences. We saw an example of this where a Muslim patient was able to have meals made that adhered to his religious beliefs.

Access and flow

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

The admission process, care pathways, and treatment plans were the same for private and NHS patients. Endoscopy staff worked efficiently according to the patient pathway to ensure patients did not have to wait unnecessarily for their procedure. Patients were currently being transferred to the surgical ward for recovery following their procedure, and when ready were discharged home.

We saw that new patient pods were being built as part of the refurbishment that would allow patients to be recovered in the day area, then discharged, meaning they would not have to be admitted to the wards while recovering.

Staff told us that there was no waiting list for admissions to the medical ward, and they were able to admit all patients that were referred to the service. Patients and relatives we spoke with did not have any concerns related to their admission, waiting times, or discharge arrangements. One patient told us they were surprised at how quickly they had been admitted to the ward.

We saw that discharge planning was initiated during admission to determine how many days patients would need on the ward. Staff also discussed potential additional support that may be needed on discharge at this time.

Staff told us that patients who were terminally ill had their choice of where they wanted to die documented in the notes, whether that be at the hospital, their own home, or other place of choice. Ward staff told us they made every effort to transfer patients to their preferred place of death within 24 hours of their request if all the relevant assessments and community resources were readily accessible.

Learning from complaints and concerns

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

The hospital subscribed to the independent sector complaints adjudication service code of practice in managing complaints they also submitted their self-assessment against the code in 2018. It was the hospital director who had responsibility for overseeing the management of complaints.

Face to face meetings with complainants at the start of the complaint were part of the complaints management process to ensure the service proactively involved patients at every step of the process and gained clarity as to the real issues and desired outcomes.

Good

Medical care (including older people's care)

A total of 99 formal complaints (written and verbal) were received and investigated by the hospital in 2018 compared to 135 received during 2017. There were 11 'red alerts' recorded through the hospitals incidents electronic reporting system those alerts were triggered by the patient feedback process in response to negative feedback that was often provided anonymously. None of the complaints were referred for independent adjudication. Majority of complaints referred to clinical treatment decisions, appointments delays or cancellation (outpatient) or financial related issues. 79% of all complaints were upheld or partially upheld by the hospital.

The hospital made changes in response to complaints and analysed patterns and trends to promote service improvements. Staff within medical care told us that complaints were discussed at ward meetings, and any lessons learnt and changes to be made would be fed back at these meetings. Staff would also share information about concerns about complaints via email.

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

Good

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

Leadership

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

The hospital director managed the director of nursing and clinical services (DoNCS), director of patient services, development director and chief finance officer. There were also heads of department for preoperative assessment and physiotherapy department amongst others.

The local leadership team were experienced and demonstrated a good understanding of the performance challenges and risks within the medical services. Senior members of staff we spoke with had been in post for several years and had a very good knowledge of the hospital and its systems and processes.

The medical staff did not share with us any negative comments about their senior or local management teams. Departmental and ward level leaders appeared competent and knowledgeable.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on improvement of services and patients experience. Leaders and staff understood and knew how to apply them and monitor progress.

There were five organisational values "beyond compliance, personalised attention, partnership and teamwork. investing in excellence, and always with integrity". Staff were encouraged to "going the extra mile and aspiring to be the best in all they do; recognising that one size does not fit all; respecting the individual; work in a coordinated and collaborative manner; doing the right thing and being respectful of others".

Leaders told us they wanted to ensure an open and inclusive culture at all levels, one in which staff communicated well, worked together to achieve organisational goals and cared for each other.

Staff attended and participated in a 'values workshop' which aimed to give staff a good understanding of organisational values. During the workshop staff were encouraged to reflect on their own values and appreciate the importance of working together to create a 'great place to work'.

Culture

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

The leadership developed numerous initiatives to improve staff wellbeing and work culture. They were inspired by the London Healthy Workplace Charter that provides a framework for action to help employers build good practice in health and work in their organisation. The framework reflects best practice and is endorsed nationally by Public Health England.

Good

Medical care (including older people's care)

The service monitored patient's safety culture through a staff survey. Where improvements were needed they had an action plan developed to address potential shortcomings. 'Patients safety survey' undertaken in 2018 indicated overall improvement in safety culture when compared to similar survey undertaken by the hospital in 2016.

Governance

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

The hospital had allocated responsibilities for overseeing quality and performance to various committees or governance groups and working parties or forums. There was a quality governance committee and medical advisory committee. The work of these committees was coordinated by the group quality governance committee.

There were established committees that oversaw medicines management, infection prevention and control and health and safety issues. There was also a social and wellbeing committee that looked at issues related to workforce.

There was an annual work programme designed to monitor clinical quality and business continuity. There were named leads responsible for preparing performance monitoring reports and ensuring specific audits were carried out and results presented at the clinical quality governance meetings. The hospital had a dedicated quality team and quality leads within each of the departments.

Managing risks, issues and performance

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

The service had a local risk register which was updated regularly. The risks highlighted on the risk register were current and control measures had been put in place to minimise it with regular updates provided. There were leads allocated to each of the item placed on the risk register responsible for overseeing mitigation actions.

The department had regular departmental meetings in addition to daily operational huddles where issues related to day to day management were discussed. There were other decision making and performance monitoring forums such as senior management meetings and heads of management meetings.

Issues related to individual areas and specialities were addressed during more specific formal meetings such as theatre users group meeting, paediatric surgical working party and operational meetings or hospital transfusion committee amongst others.

Managing information

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

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had required access to record systems to allow them to perform their work effectively.

We were not made aware of any data security breaches that occurred at the hospital within the past 12 months prior the inspection.

Access to individual patient's records was restricted to authorised staff who had varied access rights and editing privileges granted in accordance with their job role. Patient's records were stored in line with personal data security standards and entries made in patient's records could be easily ascertained attributed to the person creating them.

When required, the department submitted reports and notifications promptly to support shared learning and to share information with external bodies.

The department used information available through performance reports and local audits to inform and improve service planning. This was easily available and easy to understand for staff involved in care and treatment delivery. The information was also timely and relevant.

Good

Medical care (including older people's care)

The quality governance committee was responsible for coordinating the work of the information governance forum, which was chaired by the director of patient services.

Engagement

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

Staff told us they felt engaged in the day to day operation of the department and could influence changes. They had regular staff meetings which they used to share information related to complaint or incidents, for learning and sharing examples of good practice and to provide support to one another. Staff said they felt listened to when they had suggestions related to service delivery.

The service developed a three-year staff engagement strategy, recognising that staff engagement benefits the organisation by creating an informed, involved and productive workplace that help the achievement of the organisation's strategic objectives.

The department engaged patients by encouraging them to take part in patient surveys. Results of the survey were discussed at staff meetings and informed planned improvements. The hospital had a patient feedback review committee tasked with responding to patients comments and monitoring patients experience. The committee was chaired by the patient liaison manager.

Learning, continuous improvement and innovation

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

The hospital participated in the Association for Perioperative Practice (AfPP) accreditation scheme and its annual inspection met with all green status. The accreditation scheme offers the opportunity to demonstrate hospital's commitment to high standards of perioperative care by ensuring their educational materials, such as leaflets, brochures, or website meet pre-set standards and good practice requirements.

Good

Surgery

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

Are surgery services safe?

Requires improvement

Our rating of safe went down. We rated it as **requires improvement.**

Mandatory training

The service provided mandatory training in key skills to all staff, however did not always ensure everyone completed it.

There was system to ensure managers knew if staff had completed their training. The mandatory training matrix showed staff overall compliance and the list of training staff were expected to complete. The hospital analysed what skills were required to perform individual tasks and how frequent various mandatory training was to be delivered to individual staff. The analysis took into account job roles and prescribed if training was to be delivered using e-learning resources, face to face or if skills were to be assessed 'on the job'.

Records indicated that mandatory training completion rates oscillated between 82% and 100% amongst staff working within the inpatient environment. The hospital aimed to achieve 90% overall compliance with mandatory training completion. We noted it was lower for staff working in theatres in particular the practical part of the moving and handling training (47%), basic life support and immediate life support training amongst theatre nursing staff (68%), and paediatric life support training within the same staff group (43%). The hospital's records for training completion amongst its medical staff was 97% and it was monitored during the doctor's appraisal and local reviews.

Mandatory training compliance was discussed at the monthly departmental meetings. Achieving good compliance rate (above 90%) was one of the objectives discussed during staff's one to one meetings. The hospital had plans to link training compliance to pay reviews to encourage staff to complete their training.

Safeguarding

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

Staff we spoke with had a good knowledge of safeguarding protocols and awareness of issues they should be concerned about when treating adults, children and young adults. They spoke of appropriate examples were safeguarding protocols were initiated by members of staff. They were also aware of who to contact, should they need advice in relation to safeguarding.

Staff were required to complete safeguarding level 1 training for adults and children every three years. Level 2 training was provided to all clinical staff. Safeguarding children level 3 was provided to staff who were the safeguarding leads in their speciality, in line with the safeguarding children roles and competences for healthcare staff guidance. The training provided also raised awareness of issues related to female genital mutilation (FGM).

Cleanliness, infection control and hygiene

We found the surgical wards and theatre department to be adhering to national infection control guidance. The service controlled infection risk well. The service used systems to identify and prevent surgical site

infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

There were housekeeping staff responsible for cleaning all areas and we found all areas were maintained to a good standard of cleanliness. Patients and relatives told us they were satisfied with the level of cleanliness in the department. Areas we visited were tidy, clean, and uncluttered.

There was sufficient access to hand gel dispensers, handwashing, and drying facilities. Hand washing basins had sufficient supplies of soap and paper towels. Services displayed signage prompting people to wash their hands and gave guidance on good hand washing practice. Personal protective equipment such as disposable gloves and aprons were readily available in all areas.

We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

Clinical and domestic waste bins were available and clearly marked for appropriate disposal. We noticed information explaining waste segregation procedures and waste segregation instructions.

All patients, with an exception of the HDU patients, were placed in a single occupancy rooms on each of the surgical wards to prevent the spread of infection for example, infectious diarrhoea, methicillin-resistant Staphylococcus aureus (MRSA), tuberculosis (TB) and chickenpox amongst others.

The hospital reported no MRSA infections and one methicillin-susceptible Staphylococcus aureus (MSSA), and three escherichia coli (E-Coli) infection related to urine infections.

Staff followed the hospital infection prevention and control policy, they were bare below the elbow and used hand sanitisers appropriately. We saw staff adhering to good hand hygiene policy in all hospital areas visited.

There were infection prevention and control policies and procedures that were readily available to staff.

Environment and equipment

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

Inspection and verification of theatres was undertaken by an external contractor in April 2019 to ensure compliance with health technical memorandum (HTM) 03-01. The HTM provided guidance on the design and management of heating and specialised ventilation in health sector buildings. The inspection found that theatres maintenance and compliance level was average or good. The report indicated that some repairs to the surfaces were needed in theatre 1, 2 and 4. And that air handling units' compliance with minimum standards in theatres 1,2 and 3 was poor as they were not designed to fully conform with the suitable technical memorandums.

The hospital was working towards redesigning air extract in recovery area and exchanging flooring in theatre 1 and 2 in early 2020. They had replaced the flooring and wall upstands in theatre 4 and addressed some of the issues related to air ventilation in other theatres by replacing doors and/or air pressure grills between anaesthetic room and the corridor. These were allowing too much air to pass through the grilles and as a result the recommended differential pressures were not achieved. The hospital also replaced some of the lights and repaired celling in theatre 3's preparation room. In addition, they addressed issues related to air handling units by replacing inspection lights or exchanging belts where necessary.

Equipment we checked had servicing and electrical safety stickers on indicating it was safe to use for the designated purpose. Staff told us they felt the equipment used by them was modern and well maintained.

Resuscitation equipment stored on the resuscitation trolley was readily available and easily accessible. The hospital had systems to ensure it was checked regularly, fully stocked, and ready for use.

Assessing and responding to patient risk

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

The national early warning system (NEWS 2) was used throughout the hospital for detecting the deteriorating patient, along with a sepsis care bundle for identifying and managing sepsis. We noted that in number of cases, NEWS

2 scores were calculated without staff completing all required records for score calculation. A NEWS 2 completion audit carried out by the hospital on sample of ten records in August 2019 indicated good compliance with the required standard. Staff were provided with NEWS 2 specific training.

Surgical safety checks, in line with the guidance issued by the World Health Organisation observed at three stages were conducted. Although it was performed correctly, it did not appear to be well embedded into the theatre system. Staff demonstrated relaxed and informal attitude and the process lacked structure. We observed that in one case not all staff paid full attention.

The department undertook surgical safety checklists instead. This check involved only three steps (sign-in, timeout, sign-out) but did not ensure all five steps to safer surgery advocated by the National Patient Safety Agency (including briefing and debriefing) were undertaken correctly by theatre teams. Records indicated good compliance with the three steps.

Handover for patients transferred post-surgery to the recovery unit was thorough and complete.

Although risk assessments for venous thromboembolism (VTE), nutrition and pressure sores were initially completed accurately, staff in some cases failed to carry them out regularly as directed by the care plan. In two records, staff did note what had triggered higher VTE risk and records were not sufficiently detailed as to allow safe management of those risks were. The hospital carried out a quality audit that supposed to ensure staff completed VTE assessments correctly and it noted overall good compliance with the procedure.

Nursing staff and healthcare assistants received training on basic life support, immediate life support and paediatric immediate life support. We noted that life support training completion rate was low amongst theatre staff with 65% completion rate for basic life support training and 63% for immediate life support training. Completion rate amongst ward and the high dependency unit staff was better at approximately 85% (October 2019). The hospital did not provide training data for doctors working at the hospital.

Staff working at the HDU and senior nursing staff also received advanced life support training.

There were designated theatre staff available out of regular working hours in case of emergency. It included cover for recovery, endoscopy, and anaesthetics.

Nursing and support staffing

Managers did not have a systematic approach to regularly review and adjust staffing levels and skill mix.

The hospitals standard operating procedure stated that there should not be less than two registered nurses present on a ward during any shift. However, staff roster, reviewed for August and September 2019, indicated that on some shifts, there was only one registered nurse present supported by healthcare assistants. Staff we spoke with told us they felt on some shifts there was not enough staff and numbers of allocated nurses and healthcare assistants were varied regularly. They said it was particularly difficult to fulfil the needs of patients who underwent knee or hip surgery, if there were a few of them on the ward, as they required additional support to mobilise and were all placed in single occupancy rooms.

The hospital's patient safety survey undertaken amongst staff in 2018 indicated that only 48% of staff felt there was enough staff at the hospital. The results decreased when comparing with previous survey undertaken in 2016 and compared negatively with seven, out of eight, other locations surveyed by the provider.

A duty roster was available to staff in advance and was updated on a daily basis to reflect any changes in staff availability and bed occupancy rate. Newly appointed nursing staff were rostered with their identified mentor/preceptor.

The hospital employed 68 whole time equivalent (wte) nursing staff on its inpatient wards and within theatres. In addition, they were supported by 23.4 wte healthcare assistants and operating department practitioners (ODP).

Theatre vacancies were reported at 21%. The provider told us it was due to a national shortage of theatre practitioners. Recruitment in this area was a challenge and was included in the hospital's recruitment strategy. There were three vacancies within the recovery area covered with bank staff.

The hospital reported staff sickness rate at 3.6% and turnover rate 2.1% in 2018/2019. It was similar to other sites managed by the provider. The rate of agency staff use was low at 1.6%.

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 gave locum staff a full induction to the service.

The hospital employed four resident medical officers so one was always available on site. Each doctor worked a 12-hours shift, split between day and night duty. If a doctor was unable to complete their shift or called in unwell, a contract supplier ensured a cover doctor was arranged, however, this did not occur often.

Consultants provided out of hours support and were available to staff to respond to queries related to patients. There were designated on-call rotas that specified who was to provide support for radiology, pathology, pharmacy, physiotherapy or who was the on-call manager.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were sometimes not clear or up-to-date. Staff told us that sometimes they completed patients care and treatment records retrospectively at the time when they were finishing their shift. This meant that records were not always contemporaneous.

Although quality of records was audited to ensure it was maintained and it supported safe care and treatment delivery, we noted that records were disjointed and occasionally lacked detail. Consultants notes audit indicated only 69% met the required standard in 2018/2019. This compared negatively with other sites managed by the provider.

The service used care plan documents that were surgical procedure specific, however, staff did not always complete all required sections. We saw that urinary catheter and peripheral venous cannula management care plans were not always completed. On occasions, when staff identified a risk of deep vein thrombosis, they did not record what had triggered the risk and how to manage it. Staff used numerous care plan booklets and some additional loose record forms. For example, they used at the same time, day surgery and a procedure specific care plans, but these were overlapping in content. It led to staff completing some sections within one document and other sections in the other. This meant that records were fragmented.

Records were stored securely and easily available to all staff providing care.

Clinical staff told us they had access to current medical records and diagnostic results such as blood results and imaging reports to support them to care safely for their patients.

Medicines

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

We observed good medicines management. Stocks came from two wholesale suppliers and directly from pharmaceutical companies and pharmacists were able to source alternative supplies when required. Random stock checks of expiry dates were carried out in the main dispensary and on the wards, including liquids and topical medicine checks. We found no expired stock during our checks and noted medicines were well organised. Staff checked all fridges and ambient temperature in rooms where medicines were stored - both sets were monitored digitally and recorded continually using the wireless monitor.

To take home medicines in 85% of cases were prepared in advance to minimise delays to patient's discharge.

The service carried out an audit of prescription processing waiting times for TTO medicines in October 2018. In indicated that on average patients waited 8 minutes for medicines to be dispensed with more than 92% waiting less than 15 minutes (out of approximately 100 patients). The longest waiting time was 20 minutes.

The service also carried out an annual prescribing audit to check if prescribing took place in line with good practice in prescribing and managing medicines. The 2019 indicated overall good practice and compliance with required standards as well as an improvement when comparing with the previous year's audit. It noted that patient's full details had not always been put on patient's prescription and that when antibiotics where prescribed they did not have a review/stop date on the charts. The audit had also noted

that in some cases oxygen had not been prescribed, and there was not always a target saturation level documented. The service prepared noted actions that were to be taken in response to this audit.

All controlled drugs (CD) cupboards and registers were checked, and we found no expiry stock discrepancies. The hospital director was the CD accountable officer. CD destruction was carried out at regular intervals, in accordance with regulations.

All resuscitation trolleys were located at an easily accessible and well ventilated area, away from radiators. The medicines contained within, consumables, and cylinders were in date and records of expiry dates were also kept in the pharmacy as a backup check.

Pharmacists carried out antibiotic audits regularly, according to national guidelines and recommendations. Results were reported back to prescribers internal practice guidelines and were updated accordingly.

Clinical pharmacists checked and countersigned patient's ward charts to ensure correct medicines information was entered and the 'when required' protocols were adhered to for suitable medicines.

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. They used an electronic record system that allowed incidents to be captured, to track any actions taken in response to it, and to provide relevant staff with written feedback.

When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

The service had not reported any never events during the past 12 months prior the inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Incident reporting culture was strong, and feedback was provided to staff that reported incidents. None of the staff we spoke with mentioned any concerns about patient's safety. Significant events were also highlighted in the staff handovers and operational huddles.

Staff we spoke with felt there was a learning culture and that they could raise issues without worrying about repercussions.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service had a policy which described the duty of candour process. Staff we spoke to, understood the duty of candour requirement and its implication to clinical practice.

Pharmacists carried out a review of medicine related errors, near miss data and any related reported incidents; these were discussed in the dispensary's meeting monthly. There were 120 incidents related to medicines management reported on the hospital's electronic incident reporting system, in the 12 months prior the inspection. Staff told us the figure had increased since the 2016 visit, due to increased reporting and stronger leadership instilling a shared learning culture.

Safety Thermometer

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

Although the service was not required to report under the NHS Safety Thermometer programme, they collected relevant information and used it for measuring, monitoring and analysing patient harms and 'harm free' care.

Reports that monitored falls indicated there was 10 patients slips, falls and trips in 2018/2019; two of those resulted in harm to patients. The hospital reported that none of the patients had hospital developed pressure ulcers. During the same period, it was reported that only 80% of patients had VTE assessments undertaken within 24 hours of admission.

Good

Surgery

Records indicated that urinary catheter care plans were not always fully completed. Urinary tract infections related to urinary catheters were not regularly reported through the quality governance reporting system.

Are surgery services effective?

Good

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

Evidence-based care and treatment

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

Antimicrobial stewardship quality standard (QS121) were adhered to by carrying out quarterly audit. It checked if evidence-based guidance on prescribing practice was followed to help slow the emergence of antibiotic resistance and ensure that antimicrobials remained effective treatments for managing infections. Results of audits were fed back to prescribers.

The service also reviewed compliance with quality standards that covered preventing and controlling infection in adults, young people and children receiving healthcare in care settings. It included preventing healthcare-associated infections that developed because of treatment or from being in a healthcare setting. (NICE QS61).

The hospital used audit tools designed to facilitate hospitals to measure compliance to the NICE QS138 standard related to blood transfusion. This checked if people were offered iron supplementation when required, tranexamic acid in cases of moderate blood loss or if they were reassessed after blood transfusion amongst other quality measures.

Staff had access to clinical guidance and could make decisions based on current national guidance. However, the hospital did not have well established enhanced recovery pathways that would support patients to recover more quickly after having major surgery. This is seen as standard practice following surgery for many procedures including hip replacement or knee replacement.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. A records audit indicated that preoperative fasting was undertaken in only 67% of cases in 2018/2019. This audit was undertaken to prevent fasting prolonged beyond the recommended time for various reasons.

The service had access to dietician's support and could refer patients for ongoing support when necessary.

Pain relief

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

The hospital aimed to move away from discharging patients on high addiction risk opioid-based pain controlling medicines that relied on metabolism to work. It had increased using another medicine which had fewer side effects and had a lower risk of developing tolerance and potential for abuse or diversion (it was not to be prescribed by GPs, hence a lesser likelihood of misuse).

Patients received follow-up phone call post discharge to counsel on medicine efficacy in pain management.

The hospital carried out six monthly pain management audits to review if individual pain assessments were undertaken and if pain scores were adequately recorded and any advice and patient's wishes related to pain control were followed. Although this audit covered only small sample of records (10) it demonstrated good compliance in relation to pain management overall.

Patient outcomes

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

The hospital reported that none of the patients who underwent the hip or knee surgery at the hospital had suffered from surgical site infection.

Good

Surgery

The hospital monitored average length of stay of each patient and were able to analyse this for each of the specialities. We did not report this data due to low numbers of patients in some specialities and lack of comparable information that could lead us to drawing judgments of conclusion on overall performance.

The hospital collected patients' reported outcome measures (PROMs) related to health gain in patients undergoing hip replacement and those who needed knee replacement or cataract surgery. Reports for 2018/2019 allowed granular analysis and comparison at individual consultant level. Overall there were low numbers of patients completing PROMs surveys with 21 patients responding to the knee replacement related survey, 13 to cataract surgery and 19 post hips replacement surgery. This meant we were unable to compare the PROMs results against similar services.

Some of the comments made by patients who reported improvement post knee surgery included; "outlook on life is far more positive than it was before the operation" or "[I am} able to travel long distances with no problems [and] able to go on country walks". Others said; "[recovery] has been a much longer and harder than anticipated", "not able to play sports yet". Although, patients stated they had higher expectations than the outcomes delivered post-surgery, overall, they reported improvement in being able to participate in daily activities such as walking, shopping, or dressing. We observed similar pattern related to patients' expectations in the PROMs report related to hip replacement and cataract surgery.

The Oxford hip score results, survey designed to assess function and pain with patients undergoing hip replacement surgery, indicated improvement in patients experiencing pain and being able to participate in self-care and daily activities. One patient reported that they were "able to return to normal life [and participate in] walking swimming skiing" another patient said they "could not walk as fast as they used to".

The hospital collected and monitored information related to gender reassignment surgery. It included information on surgical site infections, 30 days post discharging from the hospital, and if a patient required emergency admission or developed a blood clot within 30 days from the procedure. The information provided by the hospital indicated that there were no such complications in 2018/2019.

In 2018 the provider implemented PROMs surveys for six other surgical procedures which included breast augmentation, rhytidectomy, rhinoplasty, liposuction, abdominoplasty, and blepharoplasty. The information was collated by an external organisation and was submitted to the Private Healthcare Information Network (PHIN) since January 2018. The provider told us submission rates were low and the majority of the patients were not due to complete the part of survey, which was sent to them six months post-surgery.

The hospital was registered with the National Breast and Cosmetic Implant Registry (NBCIR) and reported 100% submission for October 2016 to June 2018. The registry is designed to record the details of any individual, who has a breast implant operation for any reason, so that they can be traced in the event of a product recall or other safety concern relating to a specific type of implant.

Competent staff

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

The hospital reported 78% of contracted nursing, healthcare assistants and allied health professionals' staff were appraised in 2018/2019 and all the medical staff.

During the same period, only 50% of medical staff underwent practising privileges review which was required every two years.

The hospital organised in-house educational lunch sessions on new medicines or on management of patients' own drugs. Group huddles were also used for any ad-hoc learning and discussing any new developments or minor changes in practice.

Multidisciplinary working

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

Staff of different grades worked together as a team and with external professionals such as referring doctors to improve patient care and outcomes. Doctors and other healthcare professionals such as the therapists and administrative staff supported each other to provide good care.

Good

Surgery

We saw there was good liaison and collaborative working between the multidisciplinary team (MDT). All staff groups spoke highly of their colleagues and told us they had good working relationships with their colleagues.

Seven-day services

Key services were available seven days a week to support timely patient care. It included access to a high dependency unit and resident medical officer as well as on-call support provided by the named consultant.

There were designated on-call rotas that specified who was to provide support for radiology, pathology, pharmacy, physiotherapy or who was the on-call manager.

Health promotion

Staff gave patients practical support and advice to lead healthier lives. The service had access to numerous health promoting leaflets which they shared with patients prior to the surgical procedure and during their admission. It contained information related to health promotion, self-care, various medical conditions, surgical procedures, and rehabilitation amongst others.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Patients could view procedure specific videos, accessible via the internet, which were made available to them from home before their pre-assessment appointment. The videos supported their decision making and informed them of potential risks and benefits of the procedure.

Patients confirmed they consented to the procedure on the day of their surgery. Standardised consent forms were signed by both the consultant and the patients and risk and benefits were noted on them. Staff received training related to consent every three years.

Staff had received training in Mental Capacity Act 2005 (MCA) and consent. Staff were able to give clear explanations of their roles and responsibilities under the Mental Capacity Act 2005 (MCA) regarding mental capacity assessments. This was an improvement from the last inspection. The training took account of young adults and children.

Are surgery services caring?

Good

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

Compassionate care

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

Each patient was accommodated in a single occupancy room with a toilet and shower or bath for their own use. We observed staff checking if it was appropriate for them to enter before doing so. Staff carried out hourly comfort rounds when they asked if patients needed anything and if they were comfortable.

Staff were professional, friendly and polite when addressing patients or their relatives. They were willing to help and demonstrated commitment to patient-centred approach.

Patients and a relative we spoke with said they were happy with the support offered and found staff approachable and very responsive.

Staff followed the service policy to keep patient's care and treatment confidential.

The hospital undertook regular inpatients survey and analysed it quarterly. The analysis prepared by the hospital at the beginning of 2019 indicated that patients' feedback was overwhelmingly positive. Patients were encouraged to comment on their experience of the quality of care, whether they felt treated with respect and dignity, if they found nursing and medical staff professional amongst other areas. We noted that the response rate was at 50% and the hospital received between 833 and 1218 responses each quarter.

Emotional support

Good

Surgery

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

Staff treated and involved patients and their relatives as partners in assessing and meeting their emotional needs, which was understood as being crucial in the patient's care.

Staff understood the impact that patient's care, treatment and medical condition had on their wellbeing. Staff we spoke with stressed the importance of treating patients as individuals. We observed that staff spoke to patients compassionately to put them at ease and minimise their distress.

Patients identified in need of further emotional or psychological support could be referred to their GP or referring doctor for support.

Understanding and involvement of patients and those close to them

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

We observed, and patients told us, that staff were very thorough and answered all patients' questions patiently and in a considerate manner. We observed good rapport between staff and patients and staff displayed good listening skills. Evidence of patients' involvement in their care was seen in their notes.

Are surgery services responsive?

Good

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

Service delivery to meet the needs of local people

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

Staff at the hospital received a customer-service training and the service was accredited by an external organisation for its commitment to customer service. The hospital had staff members who were named 'customer service champions' and delivered customer service training to other staffwithin the organisation.

The hospital had flexible visiting times. Patients had access to a wide variety of meal choices that could meet various cultural needs and personal preferences. They had free access to hot and cold drinks and could request snacks in between mealtimes.

Each patient had access to a bathroom adjacent to their individual bedroom. Rooms were spacious. They were equipped with armchairs for visitors and overall had a pleasant appearance.

Meeting people's individual needs

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

Staff received dementia awareness training every three years. They have also received training related to equality, diversity and human rights and principles of customer service which championed the idea of individual services provision and a spirit of delivery of individualised patient-centred services. The hospital did not collect data related to cognitive assessment or dementia screening. Staff were guided by the dementia and cognitive impairment care pathway. The dementia care policy recognised that the hospital lacked expertise to allow them to be directly involved in the diagnosis and assessment of patients with possible or suspected cognitive impairment or dementia and advised staff to make external assessment referrals when it was required.

The hospital did not carry out any environmental assessments in relation to those with visual impairment or those that could not hear well. The patient led assessment of the care environment carried out in 2018 indicated that the environment was 'friendly' to patients with mobility difficulties (score of 91%) and those living with dementia (95%). The hospital improved its score when compared with the same assessment undertaken in 2017 (achieved 88% and 90% respectively).

Good

Surgery

The environment was not designed specifically to meet needs of children and young adults, but the provider had risk assessed it to ensure it was safe to this patient group.

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 standards.

The hospital collected theatre efficiency information. Staff were advised to report as an incident any delays of over 45 mins. Staff were guided by the 'golden patient results' process which described process to follow, aiming to minimise any potential delays. The hospital had late start escalation protocol that applied to members of the peri-operative care team who were responsible for the effective management of operating sessions. Data collected by the hospital suggested consultants occasionally arrived late or the list order was changed on the day. The majority of patients (80%-98% in January to August 2019) started their surgery within 30 minutes from their allocated time slot. The hospital reported that there were no cases where patients did not attend their surgery in the 12 months prior the inspection. All cancelled operations were cancelled either prior to surgery or on the day due to patient illness.

The hospital monitored the number of cancelled operations and reported it quarterly in its quality governance report. Records indicated a small number of cancellations (2-10 per quarter, out of approximate 2000 surgeries). Cancellations could occur when theatre lists over ran, when a consultant needed to attend emergency surgery at another location or where they were any issues related to equipment, for example the late delivery of implants, wrong lens ordered or lack of specialist equipment.

The hospital did not carry out formal patient discharge audits to monitor delays or out-of-hours discharges. We did not find any evidence to suggest delayed or out-of-hours discharges was a problem.

The hospital reported no out-of-hours transfers in 2018 or 2019 (until October 2019).

The hospital monitored referral to treatment standard information for patients on the 'choose and book pathway' (18 weeks wait from the time of referral to treatment). Data for 10 months of 2019 indicated that overall, 97% of patients on this pathway were treated within the required time.

Learning from complaints and concerns

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

The hospital subscribed to the independent sector complaints adjudication service's code of practice. In managing complaints, the hospital also submitted their self-assessment against this code of practice in 2018. It was the hospital director who had responsibility for overseeing the management of complaints.

Face to face meetings with complainants at the start of the complaint were part of the complaint's management process. It was to ensure the service proactively involved patients at every step of the process and gained clarity as to the real issues and desired outcomes.

A total of 99 formal complaints (written and verbal) were received and investigated by the hospital in 2018, compared to 135 received during 2017. There were 11 'red alerts' recorded through the hospitals incidents electronic reporting system. Those alerts were triggered by the patient feedback process in response to negative feedback that was often provided anonymously. None of the complaints were referred for independent adjudication. Majority of complaints referred to clinical treatment decisions, appointment delays or cancellation (outpatient) or financial related issues. 79% of all complaints were upheld or partially upheld by the hospital.

The hospital made changes in response to complaints and analysed patterns and trends to promote service improvements.

Are surgery services well-led?

Good

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

Good

Surgery

Leadership

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

Within the surgical department, there were designated heads of department, reporting to the director of nursing and clinical services, with responsibility for the high dependency unit and day unit, sterile services department and theatres manager. There were also heads of department for preoperative assessment and physiotherapy department amongst others.

The local leadership team were experienced and demonstrated a good understanding of the performance challenges and risks within the surgical services. Senior members of staff we spoke with had been in post for several years and had a very good knowledge of the hospital and its systems and processes.

The surgical staff did not share with us any negative comments about their senior or local management teams. Departmental and ward level leaders appeared competent and knowledgeable.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on improvement of services and patients experience. Leaders and staff understood and knew how to apply them and monitor progress.

There were five organisational values "beyond compliance, personalised attention, partnership and teamwork, investing in excellence, and always with integrity". Staff were encouraged to "going the extra mile and aspiring to be the best in all they do; recognising that one size does not fit all; respecting the individual; work in a coordinated and collaborative manner; doing the right thing and being respectful of others".

Leaders told us they wanted to ensure an open and inclusive culture at all levels, one in which staff communicated well, worked together to achieve organisational goals and cared for each other.

Staff attended and participated in a 'values workshop' which aimed to give staff a good understanding of organisational values. During the workshop staff were encouraged to reflect on their own values and appreciate the importance of working together to create a 'great place to work'.

Culture

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

The leadership developed numerous initiatives to improve staff wellbeing and work culture. They were inspired by the London Healthy Workplace Charter that provides a framework for action to help employers build good practice in health and work in their organisation. The framework reflects best practice and is endorsed nationally by Public Health England.

The service monitored patient's safety culture through a staff survey. Where improvements were needed they had an action plan developed to address potential shortcomings. 'Patients safety survey' undertaken in 2018 indicated overall improvement in safety culture when compared to similar survey undertaken by the hospital in 2016.

Governance

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

The hospital had allocated responsibilities for overseeing quality and performance to various committees or governance groups and working parties or forums. There was a quality governance committee and medical advisory committee. The work of these committees was coordinated by the group quality governance committee.

Good

Surgery

There were established committees that oversaw medicines management, infection prevention and control and health and safety issues. There was also a social and wellbeing committee that looked at issues related to workforce.

There was an annual work programme designed to monitor clinical quality and business continuity. There were named leads responsible for preparing performance monitoring reports and ensuring specific audits were carried out and results presented at the clinical quality governance meetings. The hospital had a dedicated quality team and quality leads within each of the departments.

Managing risks, issues and performance

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

The service had a local risk register which was updated regularly. The risks highlighted on the risk register were current and control measures had been put in place to minimise it with regular updates provided. There were leads allocated to each of the item placed on the risk register responsible for overseeing mitigation actions.

The department had regular departmental meetings in addition to daily operational huddles where issues related to day to day management were discussed. There were other decision making and performance monitoring forums such as senior management meetings and heads of management meetings.

Issues related to individual areas and specialities were addressed during more specific formal meetings such as theatre users group meeting, paediatric surgical working party and operational meetings or hospital transfusion committee amongst others.

Managing information

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

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had required access to record systems to allow them to perform their work effectively.

We were not made aware of any data security breaches that occurred at the hospital within the past 12 months prior the inspection.

Access to individual patient's records was restricted to authorised staff who had varied access rights and editing privileges granted in accordance with their job role. Patient's records were stored in line with personal data security standards and entries made in patient's records could be easily ascertained attributed to the person creating them.

When required, the department submitted reports and notifications promptly to support shared learning and to share information with external bodies.

The department used information available through performance reports and local audits to inform and improve service planning. This was easily available and easy to understand for staff involved in care and treatment delivery. The information was also timely and relevant.

The quality governance committee was responsible for coordinating the work of the information governance forum, which was chaired by the director of patient services.

Engagement

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

Staff told us they felt engaged in the day to day operation of the department and could influence changes. They had regular staff meetings which they used to share information related to complaint or incidents, for learning and sharing examples of good practice and to provide support to one another. Staff said they felt listened to when they had suggestions related to service delivery.

The service developed a three-year staff engagement strategy, recognising that staff engagement benefits the organisation by creating an informed, involved and productive workplace that help the achievement of the organisation's strategic objectives.

Good

Surgery

The department engaged patients by encouraging them to take part in patient surveys. Results of the survey were discussed at staff meetings and informed planned improvements. The hospital had a patient feedback review committee tasked with responding to patients comments and monitoring patients experience. The committee was chaired by the patient liaison manager.

Learning, continuous improvement and innovation

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

The hospital participated in the Association for Perioperative Practice (AfPP) accreditation scheme and its annual inspection met with all green status. The accreditation scheme offers the opportunity to demonstrate hospital's commitment to high standards of perioperative care by ensuring their educational materials, such as leaflets, brochures, or website meet pre-set standards and good practice requirements.

Good

Critical care

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are critical care services safe?

Good

Mandatory training

The service provided mandatory training in key skills, including resuscitation training, to all staff and made sure everyone completed It.

The service had a designated practice development nurse, who planned training sessions for staff. Staff had classroom based and e-learning sessions.

Mandatory training included information governance, equality and diversity, fire safety, health and safety, moving and handling, conflict resolution and resuscitation.

The provider target for annual staff completion of mandatory training was 95%. We saw evidence that over 98% of staff were up to date with their mandatory training. Mandatory training was comprehensive and covered all aspects of critical care, including, sepsis management, intermediate life support, safeguarding, mental capacity, deprivation of liberty (DoLs) and infection control.

Staff received training in recognising and managing deteriorating patients including those with confirmed or suspected sepsis. This was in line with National Institute for Health and Care Excellence, guidance (NG) 51, recommendation 1.12, training and education.

There was an up to date sepsis policy and all staff knew how to access it. All new nurses working at the HDU undertook a respiratory and cardiovascular study day as part of their professional development, which included a dedicated session on sepsis.

All nurses we spoke with told us that they were given time to complete their mandatory training either in a classroom setting or via the learning modules. We heard comments that included “Our managers are really supportive and make sure we have time to complete our training.” and “We are encouraged and supported to develop our skills and knowledge.”

The director of nursing and clinical services had access to the training records of staff to ensure regular checking of outstanding and completed modules and maintained a log to track the progress of each employed member of staff and the resident medical officers.

Safeguarding

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

All staff working in HDU had completed training in safeguarding adults’ level two, and safeguarding children and young people at level three. This meant all staff had received training essential to protecting patients from harm and neglect.

The provider safeguarding policy had been reviewed recently and we saw evidence of this. The policy was evidence based and followed the national intercollegiate document Adult Safeguarding: Roles and competencies for healthcare staff (2018). It was electronically available for all staff and included contact numbers for the safeguarding leads.

All staff we spoke with were aware of their responsibilities to protect vulnerable children. Staff understood

safeguarding procedures and knew how to report concerns. There was a named safeguarding lead within the hospital. Staff knew who the safeguarding lead was and were aware of the escalation process.

The service had female genital mutilation (FGM) and child sexual exploitation (CSE) policies available. Staff were aware of how to respond to concerns regarding CSE and FGM. All staff had undertaken PREVENT training as part of the safeguarding training module. PREVENT training is part of the Government's counter-terrorism strategy and aims to stop people becoming terrorists or supporting terrorism.

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 HDU was visibly clean and tidy. All soft furnishings such as tables and chairs were wipeable. Disposable curtains were in date and had a date for replacement. We saw there were wall mounted antibacterial hand gel and personal protective equipment by each bed side. We noted all staff were bare below the elbow. There were also several handwashing sinks and antibacterial hand gel dispensers inside and outside the HDU, to ensure staff and visitors had as many opportunities to wash their hands as possible. We observed staff complying with the 'arms bare below the elbow' protocol, washing their hands between patients and using personal protective equipment including gloves and aprons. This was in line with the NICE QS61 Guidance: "People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care".

The infection control lead nurse conducted monthly hand hygiene audits, which checked whether staff were washing their hands or using antibacterial hand gel at every opportunity. We viewed the service-wide audit results from January 2019 – September 2019 which showed a compliance rate of 100%.

Hand hygiene audits were carried out by the service across all four pods, with an average compliance rate of 98% between March 2018 and April 2019.

The service had an up-to-date infection control policy and staff knew how to access it. The service had a designated infection control lead nurse. All staff were involved in infection prevention and reducing the spread of hospital acquired infections.

Staff disposed of clinical waste safely. Nationally recognised colour codes were used to separate normal waste from clinical waste, sharps bins and bed linen. Bins were not over flowing and sharps bins were clearly labelled and stored safely. This was in line with, Health Technical Memorandum (HTM): Safe Management of Healthcare Waste, control of substances hazardous to health (COSHH), and health and safety at work regulations.

Staff could use the two side rooms available if patients required isolation. Staff displayed infection rates on a board in the unit, which showed that there had not been any infections in the unit for over three months from July 2019 – September 2019.

Environment and equipment

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

The unit provided mixed sex accommodation for critically ill patients in line with national guidance. Theatres were closely located providing easy access and there was central monitoring in place to allow oversight of patients.

Storage areas were organised, with doors locked. We checked equipment used at the unit and found evidence of up to date electrical safety testing. We inspected consumable items in the resuscitation trollies and store rooms in the unit and found all packets were intact and within expiry dates.

Appropriate emergency equipment was available at each bed space. There was a centrally located resuscitation trolley, a transfer trolley and bag. We found evidence of daily checks being completed and contents in line with Resuscitation Council (UK) guidelines.

Patients were protected from the risks associated with the unsafe use of equipment because staff maintained a reliable and documented programme of checks. Equipment was labelled and listed in the unit asset register. Maintenance and servicing were planned and carried out in accordance with manufacturer guidance.

Good

Critical care

Assessing and responding to patient risk

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

The unit provided level one (1) and level two (2) high dependency care, therefore staff could care for patients who deteriorated in the hospital. Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. In line with National Institute for Health and Care Excellence (NICE), guideline 51, sepsis: recognition, diagnosis and management, the service used an adapted version of the National Early Warning System (NEWS2) track and trigger flow chart. NEWS2 is a simple scoring system of physiological measurements (for example, blood pressure, temperature and pulse) for patient monitoring. The service used the sepsis six bundle and followed the provider's sepsis protocol.

Staff completed risk assessments for each patient on admission and throughout their stay to minimise risks. Access to the patient records was readily available and plans of care and treatment was actioned quickly; particularly when people where referred or when they transitioned between services.

Staff shared key information to keep patients safe when handling over their care to others. The service's electronic system had a discharge summary that was completed and added to the medical records system for the wards that the patient was discharged to. Shift changes and handovers included all necessary key information to keep patients safe. The service had a handover form with a checklist to ensure all aspects of a patient's care were handed over each shift.

All staff knew about and dealt with any specific risk issues which included pressure sores, sepsis and safeguarding, and managing invasive procedures. We were told that management of patients with sepsis was a key theme discussed at HDU monthly mortality and morbidity meetings. Sepsis training was part of the mandatory study days for staff.

The service had a service level agreement with the local NHS hospital for transfer of deteriorating patients via emergency ambulance service

Staffing

The service had enough nursing, allied health professionals 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 HDU used a safer staffing tool to calculate how many staff were needed to care for the number of patients. Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift. In accordance with national guidance. The nurse to patient ratio was one to two during the inspection.

The service had standardised shift handover procedure. This commenced with a unit wide handover led by the nurse in charge of the shift. The skill mix of the registered nurses was reviewed and patients were matched with nurses with appropriate skill sets. Following the unit-wide handover, registered nurses handed over their individual patients to the nurses taken over the care. We observed the nurse handover which was detailed and comprehensive with any safety issues identified.

There were 12 whole time equivalent (WTE) members of qualified nursing staff who worked in HDU. These included the lead nurse, senior staff nurses and other qualified nurses. Gaps in staffing were covered by moving staff between areas and staff working additional shifts and there was some use of bank staff who were already know to the unit. The HDU reported no vacancies at the time of inspection. Data provided showed a staff turnover rate of 1% for the 12 months prior to inspection. The sickness rate for September 2018 to August 2019 stood at 1%. This demonstrated continuity of staffing and was within the hospital target.

Pharmacy and physiotherapy services provided support to the HDU patients as part of their care and treatment plan.

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 unit had permanent resident medical officers (RMOs) who stayed at the hospital, and worked on a seven days on, seven days off rota. There was always one RMO on duty on a 12 hour shift.

A consultant in critical care carried out daily ward rounds. We saw that staff discussed when the consultant would be attending during handovers. Staff also discussed RMO staffing during daily safety huddles.

The consultant intensivist also provided 24 hours a day, seven days a week out of hours cover by telephone and was available to attend the hospital within 30 minutes when required.

Information provided prior to our inspection visit showed consultants and anaesthetists were engaged under practicing privileges. Consultants and anaesthetists were required to confirm suitable cover arrangements if they were unavailable or on annual leave.

Managers told us they planned and managed doctors' cover between the medical team well. Most shifts were covered inhouse, rosters were planned, and cover was organised for the full twenty four hour period, seven days a week.

Records

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

Patient notes were comprehensive, and all staff could access them easily. We reviewed two sets of patient records and saw that patients received coordinated care with clear and accurate information exchanged between relevant health professions. Documentation of the time and decision to admit to the HDU was in line with national guidance. All records were of a high standard. We saw evidence of clearly detailed summaries of events leading to the admission to the unit, multidisciplinary input into plans for care, risk assessments, monitoring of nutrition and fluid balances, consent for treatment, and discussions with patients and their families were clearly documented.

When patients transferred to a ward, there were no delays in staff accessing their records. We saw that patient record included summaries from theatres which included a surgeons handover summary, the therapeutic plan for the patient, patient history, anaesthetic information, patient allergies and the theatre nurse handover record.

The record system enabled staff to see trends in a patient's observations and pain scores by including an option to display this data as charts and graphs.

Medicines

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

We reviewed two medicine charts and found these to be completed in line with national guidance. All the medicine charts we checked had been reviewed by the pharmacist.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines**.** There was good clinical pharmacy support from a pharmacist who visited the unit daily. They were able to provide advice to patients and carers if needed.

The allergy status had been completed on each of the charts we reviewed. There was a separate section of the chart for prescribing antibiotics with clear review timescales in place. This was in line with National Institute of Health and care excellence (NICE) guidance. Oxygen and preventative treatment for venous thromboembolism (VTE) were also prescribed.

Medicines were stored securely behind locked doors with access restricted to appropriate staff. Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored securely. Two nurses checked the quantities daily and any discrepancies were reported. Medicines administration was recorded accurately, and we saw medicines were given as prescribed.

Medicines requiring refrigeration were stored correctly. We noted fridge temperatures were monitored and recorded in line with the hospital policy. Staff could explain the process of escalation if fridge temperatures were outside of the safe temperature ranges.

Medicines updates were included as part of the services learning bulletin. For example, the most recent ones included information on the antimicrobial's guidelines having been updated.

Staff followed current national practice to check patients had the correct medicines. Policies and protocols were

available for all staff on the intranet. The pharmacist was also contactable when they were not on the unit. Checks were completed when patients came to the unit to ensure they were prescribed their regular medication.

The service had systems to ensure staff knew about safety alerts and medicines incidents, so patients received their medicines safely. Medicine related alerts and recalls were communicated to the nurse in charge of the ward and cascaded to all ward staff.

All medicines prescriptions were signed and dated with all but one record documenting patient allergies to medicine. Venous thromboembolism (blood clot) prophylaxis and antibiotic medicines had been prescribed and administered appropriately in line with NICE guidelines for all patients who required them. We also saw evidence that antibiotic usage was subsequently reviewed.

There was a dedicated pharmacist for the unit, who attended regularly to review prescribing and medication charts. Staff told us they could seek advice from the pharmacist at any time and we saw pharmacists attended the daily safety huddle, so they were aware of the priorities of the HDU.

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 were aware of their responsibilities to report incidents and near misses. Staff reported incidents using an electronic system, which was monitored by senior staff and leaders.

Staff understood the duty of candour. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff could give examples of incidents where the duty of candour had been exercised including when the wrong piece of equipment had been used on a patient.

Staff understood their roles and responsibilities for raising concerns, recording concerns, safety incidents, and near misses and where to report them both internally and externally.

Policies and procedures were in place to ensure there was a methodical approach to investigating safety issues. The service made sure that actions from patient's safety alerts were implemented and monitored. The unit safety performance was in line with national standards and the service performed in line with similar services.

Managers debriefed and supported staff after any serious incident. Managers told us that those involved in a serious incident were involved in the investigation process and that all learning shared was anonymised.

There were effective systems in place to report incidents. Incidents graded by their severity from no harm, to harm including injury, suffering, disability or death. The incidents were rag rated and assigned to the clinical staff and governance leads to investigate.

Managers debriefed and supported staff after any serious incident. Managers told us that those involved in a serious incident were involved in the investigation process and that all learning shared was anonymised. There was no serious incident report between April 2018 to March 2019 in HDU.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We requested the last three root cause analysis (RCA) investigations undertaken by the service. We saw that the incidents were appropriately investigated with contributing factors and learning from the incident identified. We saw that the serious incident action plans assigned actions resulting from the serious incident report recommendations to individuals and provided a deadline for completion.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information.

Good

Critical care

The service continually monitored safety performance. Staff used the safety thermometer data to further improve services.

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

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the service reported zero pressure ulcers, zero falls and zero catheter induced urinary tract infections from September 2018 to September 2019.

Are critical care services effective?

We did not rate effective, however we found the following;

Evidence-based care and treatment

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

There was an integrated approach to assessing, planning and providing care and treatment based on national guidance and evidence-based practice. Staff followed clear and up-to-date policies and procedures. People's physical, mental health and social needs were routinely assessed. Patients' care was adapted to meet individual needs and treatment was given in line with current legislation.

The service does not submit data to the intensive care national audit and research centre (ICNARC). This meant that a range of care delivery, patient outcomes, and mortality outcomes were not benchmarked against similar units nationally, however the Aspen Group do their own bench marking against their own services.

Guidelines were followed for patients receiving Intravenous (IV) fluid therapy and patients were assessed to determine their level of risk of venous thromboembolism (VTE) in accordance with NICE guidance.

Staff followed best practice as patient needs were continuously assessed in line with national guidance. For example, staff assessed patients using the nationally recognised Malnutrition Universal Screening Tool (MUST). Records also documented use of nationally recognised tools such as the assessment of skin integrity using the Waterlow risk assessment tool.

Patients care package included assessing, where relevant, their nutrition, hydration and pain relief needs. Staff used a holistic approach to assessing patient needs on admission to the HDU, and this included their emotional and social needs as well as their physical needs.

Patients receiving intravenous (IV) medication and fluids were cared for by healthcare professionals competent in administering and assessing fluids and medications. Patients had the site of their IV medication checked daily and this was documented on the observation chart, which followed the NICE quality statement 66 Version two. Staff explained that they were able to document, fluid, nutrition VTE assessments electronically when needed. Charts within the patient records highlighted trends and flagged abnormal results.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff discussed whether patients had enough to eat and drink, and any dietary requirements during handovers. The hospital told us catering staff were trained in allergy protocols.

The unit had an emergency feeding protocol in place. This provided guidance for staff on feeding patients who were unable to eat and needed to be fed by nasogastric tube. This meant there was no delay in the feeding of patients if a dietitian was not available.

There was access to a dietitian and they would visit the unit when required. They were also available out of hours on an on-call basis. This was in line with guidelines for the provision of intensive care services (GPICS) 2019 recommendations.

Nursing staff assured us that medical staff prescribed parenteral nutrition and fluids appropriately, and our records review showed that all patients had their nutritional and fluid balances reviewed appropriately. Patient records we reviewed showed that staff were appropriately monitoring and recording patients' nutritional intake and their fluid balance (fluid intake and output).

During our inspection, we saw that water was available for those patients able to drink and assistance was provided as required for those patients who needed it. We found fluid balance charts were fully completed in each of the records we reviewed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. All the records we reviewed evidenced staff had competed the MUST risk assessment tool.

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. We observed staff checking patients for any symptoms of pain and offering analgesia in line with the services medication policy.

Patients received pain relief soon after it was identified they needed it, or they requested it.

Staff prescribed, administered and recorded all pain relief accurately. We saw that pain was regularly assessed and pain relief given where appropriate in all of the patient records we looked at. Patients we spoke with told us that their pain had been well managed by staff.

The service used a critical care pain observation tool to assess patients' pain who were sedated, and therefore unable to communicate. We saw evidence that this was used regularly in the patient records we reviewed. Patients told us that they felt safe on the unit and they had received adequate pain relief in a timely manner.

Patient outcomes

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

The HDU provided care for patients who had an elective or planned admission as well as for emergencies that included multi-organ failure. Mortality rates were between 1% - 2%, from April 2018 to March 2019 which was the same as other hospitals within the Aspen Group. At the time of our inspection, the hospital performed the same as other hospitals operated by the provider in HDU mortality, delayed discharges and out of hours discharges. The HDU service at Parkside Hospital did not submit data to ICNARC.

The service participated in local audits. The results of the audits were used to benchmark and compare with other providers nationally. Information provided prior to the inspection identified that, the service audited a range of pathways including sepsis, infection control and prevention, record keeping and medication errors. The audit report demonstrated that staff were providing safe care and treatment. Action plans were in place to improve areas in the audit that were not at the required level. This meant patients were being provided with evidence based care and treatment.

Information about the outcomes of people's care and treatment were routinely reviewed by staff. The digital patient care records collected data on venous VTE assessment, methicillin-resistant Staphylococcus aureus (MRSA) swab checks and these were reviewed by staff and action taken appropriately.

Patient handovers were undertaken using an electronic form on the system which included checks for both the nurse handing over and the nurse receiving the patient to ensure all aspects of the patient's care were handed over.

Competent staff

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

The continuous development of staff's skills, competence and knowledge was recognised as being integral to ensuring high quality care within the service. Staff were proactively supported and encouraged to develop new skills, use their transferrable skills and share best practice.

Good

Critical care

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service had an educational programme for nursing staff working in the HDU. Four nursing staff had intensive care experience and had completed critical care course. Two staff had completed step 1 competency assessment course organised by the provider and further two staff were booked to undertake the course next year.

Staff were required to complete competencies online or face to face, depending on the task. Most of the staff we spoke with on the HDU had completed relevant competencies for their role.

We were told that 98% of HDU staff had an appraisal so far in the current appraisal year and 100% in the previous full year. All staff we spoke with told us they had completed their appraisals. Staff told us that appraisals were a useful process and development was positively encouraged. All staff told us they felt valued for the work they did and it was like a second family. Objectives were set and reviewed with their line manager. All staff completed competencies training for individual skill sets. This information was kept in individual staff folders.

In addition to mandatory training, staff undertook medical devices training, mentorship and specialist procedure training such as tracheal suctioning, tracheostomy care and the use of sliding sheets. Rates of training were consistently high and an average of 95% of staff were up to date with training in the use of medical equipment. This meant staff were competent to use equipment specific to providing critical care. Staff spoke highly of their access to training and opportunities for professional development.

Bank staff were required to undertake a service specific induction, signed off by the senior nurse in charge, before commencing their first shift on the unit. This included completion of a competency checklist and review of relevant policies.

Each permanent member of staff performed a specialist link role, such as in diabetes or infection control. This meant each member of staff took the lead in their area of responsibility to attend training days and then deliver new information or practice guidance to colleagues. This system was reviewed on an annual basis and each member of staff had the opportunity to reflect on their progress and identify their training needs for the following year.

Multidisciplinary working

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

A dedicated multidisciplinary (MDT) team worked with medical and nursing staff and led a programme of early rehabilitation that ensured patients received tailored, highly specialised care from an early stage after admission. This team included physiotherapists, a clinical psychologist, specialist dieticians, speech and language therapists (SaLT) and occupational therapists. Weekly MDT meetings reviewed patients against treatment goals they developed with the therapies team.

There was a safety meeting every morning after handover, which was attended by all the nurses and resident medical officers (ROM's). The team was made aware of critical patients in the hospital.

Staff told us there were no formal MDT meetings planned on the day of the inspection. However, discussions between the consultant, nursing staff, pharmacist and physiotherapist occurred daily, as and when required, for each patient. We observed discussions between different disciplines and noted a friendly, relaxed and professional atmosphere, in which all staff were encouraged to participate and speak.

All staff we spoke with said there was good MDT working between nurses, doctors and physiotherapists. Physiotherapists worked closely with ward staff to implement rehabilitation plans for each patient. We saw nursing staff and therapists working together to complete one patient's tasks and rehabilitation plan during the inspection.

Physiotherapists were available every day and we saw evidence of physiotherapy assessments and therapy sessions in the five patient records we reviewed.

The HDU policy on admission transfer and discharge clearly stated who would and would not benefit from admission to the unit. All staff we spoke with were clear about the admission process to the unit.

Seven-day services

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

The unit was staffed 24 hours a day, seven days a week in line with the hospital's HDU admissions policy. Out of hours

cover was provided by the on-call consultant. The unit staff were able to call consultant surgeons, anaesthetists or physicians involved in patients care directly if they were required out of hours.

Physiotherapy and pharmacy services were provided seven day a week. There was a theatre out of hours service for dealing with emergencies within the service.

Patients had a follow up appointment with the physiotherapy team as part of the outpatient services.

Health promotion

Staff were consistent in supporting people to live healthier lives, including targeting those who needed extra support, through a proactive approach to health promotion and improving ill health. They used every contact with people to do so.

Staff assessed each patient's health when admitted and provided support for any individual's needs to live a healthier lifestyle. Clinicians would provide advice and support. If patients smoked, nicotine patches could also be prescribed and provided to patients. They referred patients to specialist teams as needed, for example the diabetes team, physiotherapists and pain team.

This service provided opportunities for health promotion and ongoing assessment, providing advice on rehabilitation and health promotion awareness.

A range of patient information leaflets were available for patients and families. This included information such as smoking cessation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

All nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and they knew who to contact for advice. Staff gained consent from patients for their care and treatment in line with legislation and guidance.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff completed daily mental capacity assessments for their patients as part of their observations. We saw that this was embedded practice and that managers reminded nursing staff of the importance of completing this.

Staff adhered to the systems in place to protect people from the risks associated with providing care and treatment without appropriate consent. Our review of patient records found that in all cases, consent to treatment had been obtained and documented wherever possible prior to treatment and whenever a patient's condition changed.

Staff made sure patients consented to treatment based on all the information available and staff clearly recorded consent in the patients' records.

Are critical care services 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 compassionate and responsive when caring for patients. Staff spent time to interact with patients and those close to them in a respectful and considerate way. We observed staff on the unit, talking with patients or their family and ensuring that the patient was treated with dignity and respect.

Staff maintained strong, caring, respectful relationships with the patients they cared for, and these were encouraged by the managers. Staff ensured the dignity of patients who were unconscious was protected. We saw staff introducing themselves to these patients, explaining their role and what they were going to do and why the patient was in the HDU.

Good

Critical care

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.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Nursing staff used respectful language when discussing individual patients' needs and when undertaking nurse to nurse updates/handover of patient care and progress. This included timeliness of staff responding to distress and pain.

Emotional support

Staff recognised and respected the entirety of people's needs. They understood the impact that a person's care, treatment or condition had on their wellbeing and on those close to them, both emotionally and socially.

Staff were focused on supporting patients during discharge from the unit and transfer to the wards provided re-assurance to patients until they left. Peoples emotional and cultural needs were known to be as being as important as their physical needs.

The nurse in charge visited all patients and relatives on the unit daily to assess if they had any concerns with their stay. All the patients and relatives we spoke with told us they felt supported throughout their journey. They said the support provided by staff (clinical and non-clinical) from consultation, pre-assessment, treatment and therapies was all very good. The service did not undertake HDU patient's satisfaction survey.

The HDU team offered an individualised service to elective patients to help reduce their fears and anxiety about their planned admission. For example, a nurse would meet the patient, explain the HDU environment and what to expect. They also offered the patient the chance to visit the unit and meet some of the staff.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We spoke with two relatives, who told us that staff had made them feel at ease.

Information about the cost of care and treatment was discussed with patients as part of the pre-assessment consultation before been admitted for surgery and subsequent admission to the HDU. The admission to the HDU is a planned admission to stabilise patients post surgery.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Patients' relatives told us they felt they had been included in the plan of care for their relative and that staff had made sure they understood what was happening to their relative.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We were told that importance was placed on being respectful and responsive to individual patient preferences and needs. We were also told the service ensured that patients were involved in the planning and decisions about their care.

One relative told us staff were accommodating, and they could visit or contact the unit anytime to receive an update about the patient.

Are critical care services responsive?

Good

Service delivery to meet the needs of local people

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

The HDU was a five-bedded unit that provided post-surgical and oncological high dependency care. Patients received one to one or one to two nursing, depending on their needs. The RMO was always available, and patients were seen regularly throughout the day.

The unit provided care and treatment primarily to patients after elective surgery and some medical patients. The unit did not take emergency admissions from other hospitals.

Good

Critical care

The unit could accommodate patients escalated from wards in the hospital if their condition deteriorated or unexpected complications occurred following planned surgery. There was no outreach team.

The facilities in the relatives and visitors' waiting area were well maintained and clean. There was a vending machine with a selection of hot beverages and a water dispenser.

A staff member told us that there was a standard procedure for preparing patients being transferred to the wards. This included optimising the patient's ventilation for transfer, liaising with the ward about special needs and equipment and setting goals for rehabilitation.

Meeting people's individual needs

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

Staff made reasonable adjustments to help patients access services. They coordinated care with the surgical and medical wards. People were treated as individuals and their care was designed to take all their needs into account.

Staff used a risk assessment to record the actions of patients who presented with signs of delirium. This included an assessment by the consultant or RMO to identify causes of delirium to ensure the most appropriate treatment plan was initiated for the patient. Staff worked with patients and relatives to deliver care that reflected cultural and religious needs as well as complex needs such as the care of patients with dementia.

Staff told us that a significant number of patients came from overseas and did not speak English. Staff could access interpreting services at any time either face to face or over the telephone. There was also a full time Arabic liaison co-ordinator to liaise with families and embassies.

Staff were aware of cultural differences and differing needs of patients and did their best to accommodate this. For example, female patients would be seen by a female physiotherapist if requested. Religious, cultural and special dietary meals could be sourced either within the hospital or outsourced, should patients require them.

We saw that food available catered for those with different nutritional requirements including those with food allergies, halal, kosher, vegetarian and vegan requirements. Patients spoke positively about the range of food available to them.

Access and flow

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

Admissions to the HDU were pre-planned following elective surgery. Patients were identified as requiring high dependency care at their pre-assessment check and if necessary a decision was taken to request an HDU bed. This allowed the unit to plan for the needs of specific patients. Staff in theatres and recovery told us they worked well with the HDU.

The HDU had an admission policy and admission to HDU was usually agreed by the consultant before the surgery. For planned admissions, the admitting consultant had to book the admission to the unit via the hospital's admission office. The policy stated that at no time must a patient be admitted to the unit without the consultant's permission, except in an emergency. In the event of an emergency, the hospital's RMO would initiate admission to the unit.

Consultants led discharge planning and identified exit strategies for patients when planning their admission. This meant if a patient could not be safely cared for at the hospital, consultants could recommend a more appropriate hospital.

Consultants led patient admissions with support from the RMO's and adhered to the hospital's exclusion criteria. These included a list of conditions for which the hospital was not resourced to safely treat, including certain mental health conditions such as psychosis or suicidal thoughts.

Staff were mindful of the complex needs of their patients and endeavoured to make sure patients were assigned the right level of care. Although this was a mixed sex area, staff knew about and understood the standards for mixed sex accommodation and knew how and when to report any potential breaches.

Good

Critical care

Patient bed days from April 2018 to March 2019 was 787 which makes it 43% bed occupancy rate. The latest available data indicated there were no discharge delays and short average length of stay when compared with similar Aspen Hospitals.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. Staff told us that in the event of a patient or relative wishing to complain they would ask the nurse in charge to speak to them to resolve the issue in the first instance and provide them with the details of the patient services manager.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes and shared these in the meetings. We reviewed the service's business unit meeting minutes and saw that these were discussed.

Staff knew how to acknowledge complaints and patients received feedback from managers following the investigation into their complaint. We were told by the lead nurse for HDU that there were no complaints against the service in the last year.

A complaints leaflet was available in the unit which described the complaint process should a patient want to raise a concern. There was information about how to contact the independent sector complaints adjudication service (ISCAS) if the patient was unhappy about the outcome of their complaint. Patients and relatives we spoke with were aware of the complaints process and said that staff were always there to resolve any concerns.

Are critical care services 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.

Leaders had the skills, knowledge, experience and necessary for their roles, in line with the guidelines for the Provision of Intensive Care Services, 2015. The nursing team was led by the director of nursing and clinical services, recognised as having overall responsibility for the nursing elements of the service and a designated HDU lead, who was a lead consultant in critical care.

Leaders we spoke with understood the challenges to quality and sustainability and could identify actions needed to address them.

There was a lead consultant and a lead nurse for critical care. Leadership of the service was in line with Guidelines for the Provision of Intensive Care Services (GPICS) standards.

From our observations and speaking with staff, we noted that, staff had confidence in the clinical and nursing leadership of the unit. The clinical leadership team were visible and approachable. The director of nursing and clinical services and the hospital director visited the unit regularly.

Vision and strategy

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

There were five organisational values "beyond compliance, personalised attention, partnership and teamwork. investing in excellence, and always with integrity".

The senior leadership team were able to clearly describe the unit's strategy to become an integrated unit fully compliant with The Faculty of Intensive Care Medicine's Guidelines for the provision of intensive care services and the Core Standards for Intensive Care Units. The leadership team maintained oversight on the development of the strategy and progress towards it.

Good

Critical care

Staff were encouraged to demonstrate "going the extra mile and aspiring to be the best in all they do; recognising that one size does not fit all; respecting the individual; work in a coordinated and collaborative manner; doing the right thing and being respectful of others".

The vision and strategy for the unit was developed to support the quality improvement strategy and values of patient and customer focus, continuous improvement, accountability and respect.

Senior staff had a clear vision and strategy for the service that we found was clearly understood and supported by staff we spoke with. Priorities for the HDU senior leadership team were to increase the space available for equipment storage, improve infection control in the unit and increase the number of level two HDU beds.

Leaders told us they wanted to ensure an open and inclusive culture at all levels, one in which staff communicated well, worked together to achieve organisational goals and cared for each other.

Culture

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

There was a strong team spirit and each member of staff said their contribution was valued, which meant morale in the department was high. There was good team working between nurses and the unit manager. The unit management were very committed to supporting their staff and nursing staff felt very well supported in their supervision

We saw collaborative working between the unit, pharmacy and physiotherapy teams. The team worked well together, with consultants being available for doctors to discuss patients and to give advice.

We noted that staff were proud of the team dynamics and showed willingness to go the extra mile to deliver care. All staff we spoke with were passionate about the care being provided to their patients. Staff told us they enjoyed working in the unit and they all said everyone got on well with each other. All staff spoke highly about their work and were able to contribute as part of the team.

Staff understood the importance of being open and honest when things went wrong. Staff told us that there was a culture of 'no blame' should things go wrong. We were given an example of a serious incident and how the staff involved felt supported through the whole process. No one felt that they were to blame.

The leadership developed numerous initiatives to improve staff wellbeing and work culture. They were inspired by the London Healthy Workplace Charter that provides a framework for action to help employers build good practice in health and work in their organisation. The framework reflects best practice and is endorsed nationally by Public Health England.

The service monitored patient's safety culture through a staff survey. Where improvements were needed they had an action plan developed to address potential shortcomings. The 'Patient safety survey' undertaken in 2018 indicated overall improvement in safety culture when compared to a similar survey undertaken by the hospital in 2016.

Governance

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

The hospital had clear governance structures and there were clear reporting lines from the unit to the board through the clinical governance committee. The HDU clinical governance meeting minutes were shared amongst the team via email, and also kept in a folder by the nurse's station. We reviewed examples of meeting minutes and found incidents, audits, training or feedback were discussed. 'Mortality and morbidity' was a standing item on the agenda at these meetings.

There was a governance resource folder which all staff had access to. The folder contained information about incident reports and associated learning, information for staff on clinical reviews and minutes from team meetings.

Good

Critical care

The hospital had allocated responsibilities for overseeing quality and performance to various committees or governance groups. There was a quality governance committee and medical advisory committee. The work of these committees was coordinated by the group quality governance committee. There were established committees that oversaw medicines management, infection prevention and control and health and safety issues. There was also a social and wellbeing committee that looked at issues related to workforce.

Managing risks, issues and performance

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

Data submitted prior to the inspection showed the HDU risk register was up to date and referenced ongoing risks. There were seven risks on the register, which were all relevant and reviewed regularly. All risk register items were given a colour coded red for high, amber for moderate or green for low status, dependent upon levels of risk. The risk register was reviewed monthly at the service governance meetings. Mitigating actions and updates were discussed and action plans documented. Senior staff knew about risks in their department, which corresponded to items on the risk register.

The HDU had regular departmental meetings in addition to daily operational huddles where issues related to day to day management were discussed. There were other decision making and performance monitoring forums such as senior management meetings and heads of management meetings.

Issues related to individual areas and specialities were addressed during more specific formal meetings such as theatre users group meeting, paediatric surgical working party and operational meetings.

Staff undertook mortality and morbidity meetings on a monthly basis. All members of the multidisciplinary team were invited. Minutes for the meetings clearly recorded background information to the cases discussed, details of the discussions held and any learning that was identified as part of the meeting. This meant that the minutes could be shared with those not in attendance, to ensure that learning was shared with all relevant staff. Actions were identified in response to learning that had been identified as part of the discussions held in the meeting.

Managing information

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

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. We saw that patient records were stored securely.

There were arrangements in place to ensure that data and notifications were submitted to stakeholders and regulatory agencies when required. Access to individual patient's records was restricted to authorised staff who had varied access rights and editing privileges granted in accordance with their job role. Patient's records were stored in line with personal data security standards and entries made in patient's records could be easily ascertained attributed to the person creating them.

The intranet was available to all staff and contained links to current guidelines, policies and procedures. All staff we spoke with knew how to access the intranet and the information contained therein. Staff we spoke with told us they could access the information they needed to provide safe and effective care. There were systems in place to manage and monitor care records. All staff had access to their work email and we were shown that they received organisational information on a regular basis, including clinical updates and changes to policy and procedures.

Engagement

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

The service gathered the views and experiences of staff to improve services. From speaking with staff, reviewing the minutes of meetings and from our observations, we found that staff at all levels were able to provide feedback and input into the running of the service.

Good

Critical care

Staff told us they felt engaged in the day to day operation of the unit and could influence changes. They had regular staff meetings which they used to share information related to complaint or incidents, for learning and sharing examples of good practice and to provide support to one another. Staff said they felt listened to when they had suggestions related to service delivery.

The service developed a three-year staff engagement strategy. The service recognised g that staff engagement benefited the organisation by creating an informed, involved and productive workplace that helped achieve the organisation's strategic objectives.

Feedback was sought from patients, relatives and staff about their experiences and their feedback was used to improve the service. The outcome of patients' feedback was overwhelmingly positive.

Staff attended and participated in a 'values workshop' which aimed to give staff a good understanding of organisational values. During the workshop staff were encouraged to reflect on their own values and appreciate the importance of working together to create a 'great place to work'.

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.

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

There were systems and process for learning and continuous improvement. Staff were supported by a strong ethos of training and mentoring in the service. The service had a practice educator who works across the hospital. This meant staff were able to obtain advice and support if needed. Staff were allocated to mentors for additional support.

There was a systematic and fully embedded approach to improvement, that consistently used recognised improvement methodology. Improvement was a way to sustain performance and organisational learning. Improvement methods and skills were available, and staff were empowered to lead and deliver change.

Good

Services for children & young people

Safe	Good
Effective	Good
Caring	
Responsive	Good
Well-led	Good

Are services for children & young people safe?

Good

Mandatory training

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

At the time of our inspection all staff working with children had completed mandatory training. The training covered all key areas staff needed to keep patients safe. Managers monitored mandatory training and alerted staff when they needed to update their training. All staff working with children that we spoke with confirmed they were supported to complete their training and had allocated time to undertake it. Staff said the training had given them the basic skills they required for their roles in caring for children and young persons.

The lead paediatric nurse had access to the training profiles of staff to ensure regular checking of outstanding and completed training. Mandatory training included fire safety, whistleblowing, manual handling, paediatric basic life support, information governance and conflict resolution. As part of mandatory training, staff also completed sepsis training and were all aware of sepsis management.

All staff we spoke with during the inspection confirmed they were up to date with mandatory training, and they received email or face-to-face reminders from managers when they were due to complete any of their mandatory training modules. Staff we spoke with confirmed that mandatory training was effective and meaningful for their role.

All resident medical officers (RMOs) had an up to date advanced paediatric life support training. Records showed that all nursing staff working with children had received training on paediatric intermediate life support. RMOs worked 24 hour shifts on call, therefore there was always someone on duty with this level of training.

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so.

The service had arrangements to safeguard children from abuse and neglect that reflected relevant legislation and local requirements. Staff we spoke with understood how to protect patients from abuse and the service worked well with other agencies to do so. There was a system in place to check whether all children are subject to a child protection plan were noted and flagged in the system. Staff were been provided with chaperone training.

Staff had training specific for their role on how to recognise and report abuse and they knew how to apply it. Completion of safeguarding training was 100% for all staff working with children. Medical and nursing staff working with children completed level 3 safeguarding training and had also received safeguarding supervision. The service ensured that all staff were trained to the appropriate level set out in the intercollegiate document Safeguarding Children and Young People: Roles and competencies for

Good

Services for children & young people

Health Care Staff published in March 2014. Intercollegiate guidance on Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth edition: January 2019

The lead paediatric nurse maintained regular communication with the named nurse for child protection at a local clinical commissioning group and local safeguarding children board. Staff understood how to protect children and young people from abuse. Staff were able to provide examples of how they would respond to safeguarding concerns in practice. The service had female genital mutilation (FGM) and child sexual exploitation (CSE) policies available. Staff were aware of how to respond to concerns regarding CSE and FGM. All staff had undertaken PREVENT training as part of the safeguarding training module. PREVENT training is part of the Government's counter-terrorism strategy and aims to stop people becoming terrorists or supporting terrorism. The safeguarding training compliance was at 100%. The hospital director and the director of nursing and clinical services were required to carry out safeguarding children and young people level three training as safeguarding leads. They were both up to date with this.

The service had a designated safeguarding lead for children. Staff we spoke with knew who the lead was and could describe how they would contact the person. We noted contact numbers for safeguarding issues were visible in clinical areas we visited.

There was a child safeguarding referral in policy and guidance available. The service had not needed to make a child safeguarding referral up to the time of our inspection.

Cleanliness, infection control and hygiene

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

All the areas we visited where children were treated were visibly clean and tidy. Rooms that were not in use but had been cleaned had a sign on the door informing staff the room had been cleaned and advising them to keep the door closed. Hand washing facilities and antibacterial gel dispensers were available at the entrance to the wards and on corridors.

We found all the clinical and non-clinical areas to be visibly clean and tidy. All clinical areas were cleaned between patients. We spoke with domestic housekeeping staff and reviewed cleaning logs and found no environmental issues that could potentially present an infection risk to children. We inspected treatment rooms and found them to be clean, tidy and well maintained. A cleaning audit for April 2019 found 100% compliance with internal cleaning standards. The aim of the audit was to ensure correct infection control processes and procedures were followed.

There were enough quantities of hand sanitiser, hand wash, and sinks throughout the areas visited during our inspection. Infection prevention and control (IPC) posters were in use to remind staff and visitors to wash their hands. Staff were observed adhering to hand hygiene practices.

Staff followed infection control principles including the use of personal protective equipment such as gloves and aprons. Staff were 'bare below the elbow' and we saw they adhered to infection control precautions such as using hand sanitiser before and after every time care was delivered. Staff used "I am clean" stickers to indicate equipment had been cleaned and was ready for use. Relatives told us they observed staff washing their hands and using hand sanitiser.

The service had access to isolation rooms for infectious patients and signs were placed on the doors to alert people to an infection risk.

Cleaning records were up-to-date and demonstrated that all areas were cleaned daily. There were cleaning schedules which ensured equipment and children's toys were cleaned regularly to minimise the risk of spreading infections, and we saw completed records which confirmed this. The service had a waste management policy in place and we noted that waste bins were colour coded and segregated.

Environment and equipment

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

There was no dedicated children's ward in the hospital; children were cared for in the main surgical or medical ward depending on their condition and reasons for admission. Children were cared for in a separated section of the ward by a dedicated children's' nurse.

Good

Services for children & young people

We were satisfied the arrangements around services for CYP protected children from avoidable harm and supported good care. Children and young people were cared for in a single ensuite room in the wards. The children ward areas were adapted to suit the needs of the children and young persons. There were no shared facilities within the ward for children and adult patients. Consideration had been given regarding risks presented to children by sharing the same facilities as adults and we noted that adaptations had been made to facilities and the environment for children.

There were up-to-date standard operating procedures specifically for services for CYP and all staff were aware of them and could access them easily on the providers intranet pages. There was separate recovery area for children undergoing minor procedures.

The service had enough suitable equipment to help them to safely care for children and young people. All equipment we reviewed during the inspection had undergone electrical safety testing within the last year. Equipment was maintained and serviced, which ensured it was safe to use and fit for purpose. We checked six pieces of equipment specific to CYP on the ward and found they had all been serviced within the last 12 months. The due date of the next service was clearly marked on each piece of equipment. Staff reported having enough equipment to undertake their roles. All staff received medical device training at induction and received updates when equipment changed. We saw that maintenance checks for equipment had been carried out and the date of next safety check was indicated.

Resuscitation equipment was available for all ages of CYP patients. Paediatric resuscitation equipment for first response was kept on a combined resuscitation trolley in line with UK Resuscitation Council Guidelines. Emergency equipment such as suction machine and emergency medicines were kept in the ward area near where the children were being cared for. Daily and weekly equipment checks were logged as completed by staff.

Assessing and responding to patient risk

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

Staff completed risk assessments for each child and young person on admission or arrival and updated them when necessary using recognised tools. Risk assessments completed included; pressure ulcer, moisture lesions, bed rails use, risk of falls and visual infusion phlebitis (inflammation of vein from a cannula).

Staff shared key information to keep children, young people and their families safe when handing over their care to others. We saw handover sheets were produced for staff to ensure they had the relevant information. Staff had access to a range of risk assessments on the electronic patient records system, including risk assessments for pressure ulcers, nutrition, behaviour, and pain. These were undertaken by staff during pre-admission assessment. Children's care records we reviewed showed patient risk assessments were completed appropriately and updated when required.

The paediatric early warning score (PEWS) was used for detecting the deteriorating child, along with a sepsis care bundle for identifying and managing sepsis. This included monitoring observations such as respiratory rate, pulse, and temperature. We saw a copy of the PEWS chart which showed a clear escalation plan for staff to follow depending on the PEWS score.

Staff had access to a child appropriate emergency equipment and a process was in place to respond to children and young people who deteriorated, whereby staff would dial 999 and arrange ambulance transport to acute NHS hospital. All staff we spoke with on inspection were aware of this process.

The provider had a service level agreement with NHS acute trust for transfer of children who were critically ill. The child will be stabilised on the ward and before an ambulance arrived to take them to the acute hospital for further treatment and management.

There were escalation processes to monitor deteriorating children. A sepsis tool was used to help staff escalate appropriately when signs of sepsis had been detected. We saw these were correctly used during our inspection. A range of different processes were in place for the assessment of and response to sepsis for CYP service. The provider had an overall sepsis policy that provided guidance for staff working with CYP. There were dedicated staff teams to provide expert advice to staff and care to deteriorating CYP throughout the hospital.

RMOs worked 24 hour shifts on call, therefore there was always someone on duty with this level of training. The RMO had advanced life support training.

Nurse staffing

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

There was one permanent registered children's nurse and two bank nurses. These nurses were always available when children were admitted to the hospital. Children's admission to the hospital were planned and these ensured that the nurses were available to care the child when admitted. There was a children's nurse dedicated to the outpatient clinic to support consultants treating children and young people and carrying out minor procedures. If the service required additional nursing support, the lead nurse told us they could easily book paediatric trained staff from the hospital's bank.

The CYP service at the hospital had an appropriate level of skill mix, which was in line with the Royal College of Nursing (RCN) guidelines: Defining staffing levels for children and young people's services. This guidance states that the ratio of registered to unregistered staff in children's nursing teams should not fall below a 70:30 ratio. The guidance also describes different nursing levels required according to age and dependency. At the time of the inspection, the service only had appropriately registered, qualified and experience RSCN working with children in the hospital. There were no healthcare assistants working in CYP services.

The Royal College of Nursing (RCN) guidance on defining staffing levels for children and young people's services required a ratio of one nurse to four children (1:4) over the age of two years during the day and at night. The guidance required 1:3 nursing ratio for children under the age of two. The service performed better than this standard. On average, the ratio of nurse to child was one to two, due to the small nature of the service. A duty roster was available to staff in advance and was updated daily to reflect any changes in staff availability and bed occupancy rate.

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.

All children and young people were cared for by a named consultant with practising privileges at the hospital. All consultants caring for children and young people in either a surgical or anaesthetic context, were required to provide evidence that they undertook clinical paediatric activity within their scope of practice in the NHS, and this was recorded on the consultant register. Practising privileges were reviewed by the medical advisory committee twice a year.

A consultant paediatrician was available at the hospital whenever a child was admitted, and this was in line with the Royal College of Paediatrics and Child Health and British Association of Paediatric Medicine guidelines.

There was a requirement for all consultants with practising privileges working in the hospital to be available either by phone or in person when required, or to arrange appropriate named cover when they had patients in the hospital. Part of the consultant's practising privileges agreement was they should reside and work within a reasonable travel time of travel to the hospital (at most 30 minutes of travel time). Most of the consultants with practising privileges were also employed by the local NHS trusts; staff told us it was easy to contact them when needed.

Royal College of Paediatrics and Child Health guidelines required every child admitted to a paediatric ward to be seen by a paediatric consultant within 14 hours of admission. The service exceeded this standard. An audit of consultant ward round report indicated that, all children admitted to the hospital were seen by the consultant within an hour of admission.

Records

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

The service used care plan documents that were specific to surgical procedures specific for children admitted to the hospital. Staff kept detailed records of patients' care and treatment. Patients records were paper based, the records

we reviewed were clear, legible and up-to-date. Quality of records were audited to ensure they were maintained and supported safe care and treatment delivery. We noted that records were detailed and legible. Medical records audit indicated 98% met the required standard in 2018/2019.

The World Health Organisation surgical safety check list was included in the paediatric care record for completion when a child or young person attended for an invasive procedure. This had not been audited at the time of our visit as there had not been a great enough number of procedures for children and young people to give a significant result. We were told this was to be undertaken when numbers had accumulated.

The patient records were accessible by doctors, nurses and other healthcare professionals. This meant all professionals involved in a patient's care could see the record. We reviewed eight sets of medical records and saw patients care plans included all identified care needs.

Individual care records for children were kept by their bed. These records gave details of assessments of the needs of the child or young person and documented vital signs such as heart rate, blood pressure and temperature. All entries we saw were signed, timed and dated by the professional completing the assessment or delivery of care.

An assessment tool was used to support the nursing staff in identifying risks relating to a deteriorating condition with guidance included on recommended actions to escalate the risk. We saw this had been completed and used appropriately on the records we viewed.

Clinic staff used paper-based patient records to record patients' consultation, assessment and operative records, as well as post-operative care and risk assessments. All patients having day case procedure at the hospital were required to complete a pre-assessment medical questionnaire. This included questions about any recent surgery, medications, any treatment for any medical conditions and allergies. We saw pre-assessment checks and risk assessments were present in records we reviewed.

All of the patient records we reviewed during the inspection had the name of the nurse and consultant clearly documented with an individualised care plan for the treatment provided. All had risk assessments and screening completed, including safeguarding and mental health where appropriate. All had venous thromboembolism risk assessments and patient observations recorded.

All the records we reviewed had pain assessments and vital signs records signed and dated, and where patients were prescribed antibiotics these had been reviewed.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Controlled drugs were stored, recorded and handled correctly and within national guidance. Spot checks on balances showed that contents of the cupboard matched the register. All medicines were noted to be stored securely and safely. Two qualified nurses checked drug stocks daily and a spot check of the CD register confirmed levels were correct. All nursing staff were aware of policies on administration of controlled drugs as per the Nursing and Midwifery Council – Standards for Medicine Management.

Medicines requiring cold storage were stored in dedicated medicine fridges and fridge temperatures were recorded daily. We saw these were documented and temperatures were within range.

All resuscitation trolleys were located at an easily accessible area of the ward. The medicines, consumables and oxygen cylinders on the resuscitation trolley were in date and records of expiry dates were also kept in the pharmacy as a backup check.

Clinical pharmacists carried out antibiotic audits regularly, according to national guidelines and recommendations. Results of the audit were reported back to prescribers, and action plan with revised practice guidelines were updated and implemented accordingly as per the results of the audits.

Medicine administration records had patient allergies recorded. We saw in practice that a patient was wearing a red allergy band. The hospital had an antibiotic policy and developed an audit tool for antimicrobial prescribing, to assist in promoting standardisation of prescribing between surgeons. Microbiology advice was available from the service's infection prevention and control (IPC) committee who was chaired by the consultant microbiologist and IPC lead for the service. Audit outcomes and any issues around individual surgeon's practises were discussed at the medical advisory committee (MAC). We were told the

hospital's medicines management policy had recently been updated and approved by the Medication Management Committee, to ensure it met with professional standards for medicine management.

Clinical pharmacists checked and countersigned patient's ward charts to ensure correct medicines information was entered and the 'when required' protocols were adhered to for suitable medicines. We saw staff had documented any medicine allergies in patients' notes.

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.

The service had a policy for the reporting and investigation of incidents, near misses and adverse events which was in date. Staff were encouraged to report incidents using the electronic incident reporting system. The staff we spoke with could describe the process of incident reporting and understood their responsibilities to report safety incidents including near misses. There were 15 CYP related incident report from April 2018 to March 2019, all of which had been classified as no harm incident.

There were no CYP related incidents classified as 'never events' reported from April 2018 to March 2019. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Staff reported all incidents following the expected procedure. Staff gave us examples of when they had completed incident forms and told us they consistently got feedback from managers and lessons learned were disseminated. Staff told us they discussed incidents and learning from investigations during their staff meetings. We saw this was the case when we attended a hospital-wide huddle during our inspection.

Incident reporting culture was strong, and feedback was provided to staff who had reported incidents. Significant events were also highlighted in the staff handovers and operational huddles. Staff we spoke with felt there was a learning culture and that they could raise issues without worrying about repercussions.

Staff we spoke with had a good knowledge of duty of candour regulation. The service had a policy which described the duty of candour process. Staff we spoke to, understood the duty of candour requirement and its implication to clinical practice. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Safety Thermometer

See surgery report for safety thermometer information.

The NHS safety thermometer is an improvement tool to measure patient harms and harm-free care. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheter associated urinary tract infections. The hospital was not required to use the safety thermometer as it was a private healthcare provider. However, the hospital collected this information as part of their quality and safety performance monitoring and review process.

Between April 2018 and March 2019, the hospital reported no falls, no pressure ulcers and no cases of catheter associated urinary tract infections and no case of VTE for CYP services.

Are services for children & young people effective?

Good

Evidence-based care and treatment

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

Staff had access to and followed up-to-date policies to plan and deliver high quality care according to best practice and

national guidance. This guidance included the National Institute for Health and Care Excellence, Paediatrics and Child Health, Royal College of Nursing and British Association of Paediatric Medicine guidelines.

Staff assessed patient's physical, mental health and social needs holistically, and their care and treatment were delivered in line with legislation, standards and evidence-based guidance, including National Institute for Health and Care Excellence (NICE). We noted that handovers routinely referred to the psychological and emotional needs of patients, as well as their relatives and carers.

Patient records we reviewed showed treatment followed national guidelines. For example, National Institute for Health and Care Excellence: Intravenous fluid therapy in children and young people in hospital. The service adapted and monitored compliance against NICE guidelines and took steps to improve compliance when further actions had been identified.

Nutrition and hydration

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

Patients and their relatives we spoke with said they had a choice of meals and these took account of their individual preferences, including religious and cultural requirements. The provider rated themselves as being compliant with 10 key characteristics of good nutritional care in hospitals as stipulated by the Council of Europe Alliance.

All patients attending for treatment were screened using the Malnutrition Universal Screening Tool (MUST) on the service electronic system.

The staff followed the Royal College of Anaesthetists guidance on fasting prior to surgery. The guidance suggested patients could eat food up to six hours and drink clear fluids up to two hours before surgery. Pre-operative CYP patients were advised on fasting times prior to surgery. Patients having operations in the afternoon could have an early breakfast on the day of surgery and this was in line with best practice. We saw nursing staff asked patients to confirm the last time they ate and drank before surgery. This ensured the service complied with the Royal College of Anaesthetists guidelines.

Staff followed national guidelines to make sure patients fasting before surgery were not without food and water for long periods. Children's records audit indicated that preoperative fasting was undertaken in 97% of cases in 2018/2019. This audit was undertaken to determine an appropriate fasting period before surgery so that patients were not kept nil by mouth for long period beyond the recommended pre-operative fasting time for various reasons.

The service had acted on feedback from children and families to improve the choice and availability of food. Staff worked closely with anaesthetists and theatre staff to ensure children were kept nil by mouth for the minimum amount of time.

Pain relief

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

A pain management assessment tool was in place that was specific to CYP needs. A pain management guidance for staff had been written by the lead paediatric nurse and pharmacist and was reviewed at clinical governance meetings. It detailed prescribing guidelines for all ages, identifying level of pain and appropriate medication, and any associated risks. Guidance was also included for pain relief when patients were discharged.

We saw how staff assessed pain experienced by children post-operatively using age specific assessment tools.

Local anaesthetic was used for children who needed intravenous cannulation to numb the area and prevent pain.

The hospital carried out six monthly pain management audits to review if individual child pain assessments were undertaken and if pain scores were adequately recorded and any advice and patient's wishes related to pain control were followed. Although this audit covered only small sample of records (10) it demonstrated good compliance in relation to pain management overall.

Patient outcomes

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

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

At the time of our inspection the hospital performed the same as other hospitals operated by the provider in children's service mortality, delayed discharges and out of hours discharges. The hospital provided information to the Private Healthcare Information Network (PHIN). This included information on length of stay, patient satisfaction and the number of patients seen. PHIN ensures robust information is received about private healthcare to improve quality data and transparency.

There was a clear pathway for CYP patients undergoing orthopaedic and day case surgical procedures including a pre-assessment where patients were given information in the form of a detailed leaflet. Patients and their relatives were also told about pre-surgery interventions and given a tour of the wards they will be admitted to during their stay at the hospital.

The hospital governance report indicated the management would be investigating cases where patients reported worsened symptoms to enable them to make changes to practice. Minutes of the clinical governance meetings showed patient outcomes were shared across departments, through this meeting.

The theatre department had an annual audit programme to measure performance. We saw the audit schedule, which included areas such as anaesthetics and pain management.

Each consultant monitored the results of procedures and treatment for their patients. There was no established system for monitoring readmission rates for CYP patients. Parents were encouraged to contact the hospital if there were any concerns post procedure. We were told the local NHS hospital would inform the hospital if any child who had been admitted to the hospital following a procedure at Parkside hospital.

There was a hospital-wide audit schedule which covered a range of areas including compliance with record keeping and medicines. The service participated in local audits. The results of the audits were used to benchmark and compare with other providers nationally. Information provided prior to the inspection identified that, the service audited a range of pathways including sepsis, infection control and prevention, record keeping and medication errors. Action plans were in place to improve areas in the audit that were not at the required level.

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.

Staff told us they had good access to professional development, and their managers were supportive of them to go on external courses. All staff we spoke with had completed relevant competencies for their role.

All staff working with children had undergone CYP training and were competent in the care and treatment of CYP patient. Radiographers, sonographers and physiotherapists working with children had completed paediatric training within their educational and training qualification. CYP service ultrasound scans were performed by radiologists experienced with children and young people.

Consultant appraisal summary documents were linked to their NHS practice appraisals. These were reviewed at the same time as practising privileges. Practising privileges were renewed by the hospital every two years. This meant the hospital had ways to monitor each consultant and ensure procedures were in place to monitor performance.

RMO's received mandatory training from their employing agency, which included for example, sepsis, advanced life support and infection prevention and control. In addition, they completed on-line continuous professional development modules. The RMO was supported by nursing and management staff and had daily communication with consultant colleagues.

All nurses working with children were paediatric trained and were provided with additional courses for the care of children and had attended yearly refreshers courses. All registered children's nurses had attended paediatric immediate life support training and the RMO had the

paediatric advanced life support training. CYP nursing staff were encouraged to develop their skills and competencies. The lead paediatric nurse had attended CYP specific training on patient care.

Ward and theatre staff working with CYP had undertaken CYP competency assessment and had attended yearly appraisal. All staff we spoke with said they were appraised last year and had found the appraisal process beneficial and positive.

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

The hospital reported 98% of contracted nursing, healthcare assistants and allied health professional staff were appraised in 2018/2019. At the time the inspection 98% of staff were appraised

Multidisciplinary working

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

Staff spoke of a good working relationship with regular paediatric consultants who attended the hospital to carry out surgeries or hold clinics. Staff described communication with teams and departments as good.

Information regarding CYP services was shared with all staff by the paediatric nurse and at team meetings. The lead paediatric nurse was a member of several committees within the hospital including infection prevention and control, resuscitation, theatre group and clinical governance.

Patient records contained details of all the multidisciplinary input in treatment which included medical, nursing and anaesthetic teams and recovery staff input.

A dedicated multidisciplinary team (MDT) worked with medical, surgical and nursing staff and led a programme of early rehabilitation that ensured CYP patients received tailored and highly specialised care from an early stage after admission.

All staff we spoke with said there was good MDT working between nurses, doctors and allied health professionals.

Seven-day services

Key services were not available seven days a week, due to low patient numbers. However, services were arranged to support timely care for children, young people and their families.

Theatre operating schedules for CYP were carried out either one or two days a fortnight.

Paediatric outpatients' clinics were held on most weekdays depending on the child's needs and consultant availability. Children could also have appointments with individual doctors with paediatric practising privileges on any day they worked at the hospital.

The RMO was on site 24 hours a day seven days a week. They were able to access support from consultants who visited their patients daily as part of the pre and post-operative care pathway. The nursing staff told us they had good working relationships with the consultants and had no hesitation in contacting consultants at any time to discuss their patient's care and condition.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

Staff worked with families to improve the quality of the child or young person's life and to enable them to make informed decisions and choices. Staff assessed each child and young person's health when admitted and provided support for any individual needs to live a healthier lifestyle.

There was a variety of different information available in relation to making healthy lifestyle choices for example healthy eating and taking physical exercise. In addition, there was information about living with a long-term health condition and signposting to support agencies.

Staff gave patients practical support and advice to lead healthier lives. The service had access to numerous health promoting leaflets which they shared with patients prior to their surgical procedure and during their admission. It contained information related to health promotion, self-care, various medical conditions, surgical procedures, and rehabilitation amongst others.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Good

Services for children & young people

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

We saw there was appropriate signed consent for children attending for elective surgery in all records we looked at. Staff were aware of and able to describe how consent issues changed as children became older and were more able to make their own choices. Staff told us they would refer to Gillick competency and Fraser guidelines, and seek advice from the lead paediatric nurse, director of clinical services, or external safeguarding contacts if required.

Staff made sure children, young people and their families consented to treatment based on all the information available. Patients and their families told us staff explained treatment in a way they could understand and sought their consent before proceeding.

All the staff we spoke with had a sound understanding of the need for informed consent to be obtained before providing care or treatment. Verbal consent was sought each time staff carried out any examination, observations or provided treatment. This was usually from both the child and their accompanying parent. Records seen indicated that written consent was obtained from the parents of the child prior to surgery or other interventional procedure.

Staff told us if patients were experiencing mental ill health they would liaise with Child and Adolescent Mental Health Services (CAMHS), based at a local NHS trust.

Are services for children & young people caring?

We did not rate caring because we only saw a small number of children using the service on inspection. The service saw 237 children and young people for day case treatment between March 2018 to February 2019.

- The service provided a caring and compassionate service, which involved patients in their care.
- Confidentiality and dignity were respected by staff and patients felt supported by staff.
- Staff provided emotional support to patients and patients had access a range of services required.

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Feedback from children, young people and their families was positive about the way staff treated them.

We observed warm, open and positive interactions between staff and patients. We saw that staff communicated in a way that was easy to understand and that they modified their tone, language and pace of conversation to suit the patient.

Staff followed policy to keep care and treatment confidential. Staff understood and respected the individual needs of each child and young person and showed understanding and a non-judgmental attitude when caring for children and young persons.

Emotional support

Staff recognised and respected the entirety of people's needs. They understood the impact that a person's care, treatment or condition had on their wellbeing and on those close to them, both emotionally and socially.

The service allowed children to express their views and be actively involved in decisions about their care and treatment wherever possible.

Patients' needs were always assessed by staff to ensure they were given emotional support by staff. Patients were given emotional support from staff throughout their stay in the hospital.

Parents we spoke with told us how the nursing staff talked to them and their children to relieve any anxieties. We continually observed staff providing emotional support to families. We observed nursing staff supporting families of children through their approach to the initial assessment. Feedback from children and those who are close to them was continually positive about the way staff treat people.

We were told CYP patients and their families were encouraged to attend pre-admission tours of the hospital

facilities, so they could orientate themselves to the hospital and the wards they would be staying on. This helped them become familiar with the environment and gave them the opportunity to prepare for their visit.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

When a child attended the hospital for surgery, the paediatric nursing team saw the child beforehand to help to explain what would happen and admit the child to the ward.

Information about cost were provided to the families before their admission, and the hospital operated a cooling off period should in case families wanted to change their mind.

Staff we spoke with described how treatments would affect children and young people showing an understanding of how patients may feel.

Parents told us they were kept informed and felt involved in the care plan of their child. Children we spoke with told us they felt everything was explained to them and they knew what to expect.

Parents and carers we spoke with during our inspection provided positive feedback about the extent to which they had been involved in their child's care.

Staff introduced themselves and updated children, young people and their parents or carers about any delays where relevant and explained any reasons for this. Staff were observed providing information about any care or treatment they were due to provide, including potential side effects and benefits where relevant. Staff explained the outcome of assessments and reviews, including using pictorial charts and images.

Parents were supported to stay and be involved in delivering their children's care as much as possible to ease their distress when safe to do so, and under the guidance and supervision of the nurses.

Are services for children & young people 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.

Staff at the hospital received a customer-service training and the service was accredited by an external organisation for its commitment to customer service. The hospital had staff members who were named 'customer service champions' and delivered customer service training to other staffwithin the organisation.

Each child had their own room on the ward. We saw these rooms were decorated in a child-friendly manner, and the rooms in outpatient's department contained a selection of toys, books and other materials that could be used for distraction. Each patient bedroom had access to a bathroom and the rooms were spacious and were equipped with armchairs for visitors and overall had a pleasant appearance. There was also a dedicated paediatric recovery area for children post operatively.

CYP admission dates were planned for each patient during initial consultations to determine day case bed availability. The booking co-ordinator and theatre manager arranged the CYP operating lists for theatre in collaboration with each consultant's secretary.

The hospital did not provide emergency care for children and all admissions were planned and arranged in advance. The hospital had a service level agreement (SLA) with the local NHS trust with regards to dealing with children emergencies that may arise during their stay at the hospital.

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Staff told us that they could access language interpretation services (with face to face interpretation where necessary) and we were told that patients information leaflets could be produced in different languages if needed.

Pre-admission assessment appointments were provided to ensure effective planning of admissions. The hospital provided CYP care and treatment including diagnostic procedures at the same location. Patients had a consultation and examination during their first visit. A subsequent pre-operative assessment appointment was provided to patients prior to their admission.

All children were admitted as a day case in the hospital. There was no dedicated paediatric theatre list. Children were seen and scheduled first on the main theatre list. This ensured that they were treated early, recover well in time and be discharged home on the same day.

Arrangements were in place to access translation. Staff we spoke with told us they knew about the service and used it when patients, whose first language was not English, attended pre-operative assessment and when admitted on to the ward.

There were no set visiting times at the hospital, visitors were asked to contact the hospital first to see if it was appropriate to visit.

If a patient with a learning disability was identified during initial assessment there was a facility for staff to flag their records to refer them for a specialist support from a learning disability link nurse.

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 service targets.

The service had systems and processes in place to monitor access and flow and to ensure that they were responsive to the needs of patients. CYP patients could access the service within 24 hours of been referred to by the GP or referring consultant. Patients could contact the service via telephone to enquire about treatment both within and out of opening hours. Patients could go directly to a consultant who would then assess the patient's fitness for treatment. The service provided patients with pre-treatment consultations to identify any risks, allergies and other general patient care needs.

The paediatric lead nurse was informed of all CYP patients attending for a procedure at the hospital. There was a weekly meeting between the director of nursing and clinical services, the lead nurse and the lead paediatric nurse to review all planned paediatric admissions to ensure there were appropriate staff on duty. CYP patients were screened to ensure admission was appropriate before they were allocated a date for the procedure.

The hospital had a pre-assessment service and assessed patients prior to surgery using the American Society of Anaesthesiologists (ASA) physical status scoring system. CYP patients admitted to the hospital were of low risk and any issues concerning discharge planning or other patient needs were discussed and documented at the pre-assessment stage.

The service had a variety of different specific pathways and services that ensured patients were treated in the right place at the right time by appropriately trained and competent children nurse. There had been about 237 children and young people admissions between March 2018 to February 2019.

The hospital offered surgery and outpatient appointments for CYP patients Monday to Saturday and in the evenings where possible. Where possible; appointment and treatment times were undertaken at a time suitable to the patient.

Information about dining facilities and opening times for the restaurant and coffee shop was displayed on a poster in the hospital.

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 services had a system in place to encourage complaints and compliments with a view to improving services for patients. The service treated concerns and complaints seriously. Managers investigated complaints, identified themes and shared lessons learned with all staff.

Good

Services for children & young people

The hospital received 18 complaints between January to March 2019, however none of this related to CYP. There were no CYP related complaint from April 2018 to March 2019. All our complainants were offered a face to face meeting and all were resolved/closed off within the required time frames.

Patients and relatives had several ways of making a complaint. Complaints could either be raised verbally by speaking to the most senior member of staff on duty that day, or service users could make a complaint in writing or over the phone to the service manager. We found leaflets on all the wards we visited informing people about how to make a complaint.

Staff we spoke with were aware of the complaints policy and how to access it. Staff told us they tried to resolve complaints and concerns immediately whenever possible. Staff were aware of the raising a concern at work policy. Complaints were discussed at the weekly quality review group meetings. We saw evidence of this in the minutes of quality review group meetings. Learning from complaints and concerns was discussed a team meeting.

Are services for children & young people 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.

The hospital had a clear management structure led by the hospital director with the director of nursing and clinical services leading all clinical services. Staff told us that they knew who the leadership team were and knew that they would be listened to if they raised concerns. All staff we spoke with knew who the paediatric nurses and consultant paediatricians were and felt they could always approach them for advice and support.

Managers had the skills, knowledge and experience to manage the service, they demonstrated the ability to understand the challenges they faced and developed plans in order to deal with these challenges.

Consultants we spoke with felt there was a good working relationship and engagement with the hospital leadership team and staff and that they were involved with clinical governance issues. Consultants we spoke with regarded the executive director and matron as effective and approachable.

Staff told us their leadership team was approachable and visible. Staff described the hospital directors having an open-door policy with access as and when needed.

The director of nursing and clinical services led nursing teams on the wards and departments and were supported by lead nurses, senior and junior sisters on each ward.

Vision and strategy

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

There were five organisational values "beyond compliance, personalised attention, partnership and teamwork. investing in excellence, and always with integrity". Staff were encouraged to "going the extra mile and aspiring to be the best in all they do; recognising that one size does not fit all; respecting the individual; work in a coordinated and collaborative manner; doing the right thing and being respectful of others".

The service had a CYP vision and clinical strategy in line with the national recommendation, which was incorporated into the hospital wide vision and strategy. Staff within the CYP service had clear visions on where they wanted their services to be. Staff within the CYP subspecialties had clear visions on where they wanted their services to be. There was good shared vision within the subspecialty services of children's surgery, diagnostic imaging and physiotherapy services.

Leaders told us they wanted to ensure an open and inclusive culture at all levels, one in which staff communicated well, worked together to achieve organisational goals and cared for each other.

Staff attended and participated in a 'values workshop' which aimed to give staff a good understanding of

organisational values. During the workshop staff were encouraged to reflect on their own values and appreciate the importance of working together to create a 'great place to work'.

Culture

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

There was a strong team spirit and each member of staff said, in their opinion, their contribution was valued, which meant morale in the service was high. There was good team working between nurses and their manager. Nurses and clinical leads were very committed to supporting their staff. All staff told us they felt valued for their work. Staff said they felt listened to when they had suggestions related to service delivery.

There was a culture of positive action to improve the service in safety and quality. Meeting notes we saw documented how identified improvements were being acted upon. Staff were able to tell us the changes they had made to meet the needs of children, including separate play areas and provision of child friendly admission pack. Staff we spoke with felt valued and listened to. They felt they had a voice that could make positive changes for the service.

We were told the service encouraged and supported staff development as part of its learning culture. Staff had one day a month dedicated to further learning and team meetings. Staff told us that this day was well utilised and was well supported by managers and senior leaders. We noted staff were proud of the team dynamics and showed willingness to go the extra mile to deliver care. All staff we spoke with were passionate about providing empathetic care. Staff told us they enjoyed working in the department and all said everyone got on well. All staff spoke highly about their work and were able to contribute as part of the team.

We saw collaborative working between the service, pharmacy and physiotherapy teams. Newly employed nurses felt very well supported in their probation and supervision. The team worked well together, with consultants being available for nurses to discuss patients and to give advice.

Staff understood the importance of being open and honest when things went wrong. Staff told us that there was a culture of 'no blame' should things go wrong. We were given an example of a serious incident and how the staff involved felt supported through the whole process. No one felt that they were to blame.

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.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Leaders operated effective governance processes throughout the service. The CYP clinical lead reported to the director of nursing and clinical services.

The hospital had allocated responsibilities for overseeing quality and performance to various committees. There was a Quality Governance Committee and Medical Advisory Committee. The work of these committees was coordinated by the Group Quality Governance Committee. The CYP lead nurse was the nursing lead for the CYP services, and was accountable to the director of nursing and clinical services.

There were established committees that oversaw medicines management, infection prevention and control and health and safety issues. There was also a social and wellbeing committee that looked at issues related to workforce.

The Medical Advisory Committee (MAC) was held quarterly and chaired by a lead consultant. It was attended by a CYP lead consultant and consultants from each speciality with practising privileges, the hospital director and the matron. Minutes demonstrated standing agenda items covering clinical governance, practising privileges, clinical specialty issues and these were circulated to all consultants.

The MAC advised the hospital management on all clinical, quality and safety matters affecting the hospital such as the granting of practising privileges, scope of consultant

practice, consultant appraisal and revalidation, continuing practice development, patient outcomes, clinical standards and implementing new and emerging professional guidance.

There was an annual work programme designed to monitor clinical quality and business continuity. There were named leads responsible for preparing performance monitoring reports and ensuring specific audits were carried out and results presented at the clinical quality governance meetings. The hospital had a dedicated quality team and quality leads within each of the departments.

Managing risks, issues and performance

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

There were clear process and systems for leaders to escalate risk and performance issues via committees and to the board. The leadership team received information to support them in managing risk, identifying issues, and assessing performance.

Leaders used electronic systems and performance dashboards to manage current and future performance. These allowed the leadership team to have an effective system to identify, monitor, understand and address current and future risks. This was supported by a detailed risk register, which had recently been reviewed and all risks re-rated and reflected issues that staff and the leadership told us they were concerned about.

We spoke with members of the leadership team about how they measured quality and performance. The team had access to various sources of information, such as ward metrics, which captured a series of indicators ranging from documentation audits to hand hygiene. This information was examined, discussed and action taken through the clinical governance meetings. Every month the management received a dashboard for the service to monitor quality. This also looked at compliance with key targets and standards, so staff could see where improvement was needed.

We discussed with the leadership team the risk register. Risk registers were maintained at various service level but also on the wider provider risk register and depending on the risk score, to the organisational wide risk register. The risks on the risk register were the same ones we saw during the inspection. The risk register process above ensured that all key risks highlighted were subject to the appropriate level of scrutiny, frequent review and a continual process to effectively manage the risk.

Managing information

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

From speaking with staff and reviewing information supplied in electronic format prior to the inspection, it was clear that staff at all levels could access information in a digital format which could be interpreted and rapidly used to help improve the service.

We observed good adherence to the principles of information governance. For example, computer screens were locked when unattended and records were kept secured and locked. Staff compliance with information governance and data protection training as part of the annual mandatory training was 100% within the CYP service.

The service had processes in place to capture, record and submit data to the Private Healthcare Information Network (PHIN). There were effective arrangements in place to ensure that data and notifications were submitted to external bodies when required including sending notifications to the Care Quality Commission.

All staff had access to their work email, where they received organisational information on a regular basis, including clinical updates and changes to policy and procedures. There was a shared drive available to all staff, which contained links to current guidelines, policies and procedures. Staff knew how to access this, and the information contained within.

Monthly team briefs and integrated quality and learning reports, using qualitative and quantitative information, using charts for quality indicators were produced by the provider. Performance dashboards were used for staff to discuss and monitor performance at monthly senior

management team meetings. We saw that patient records were stored securely. There were arrangements in place to ensure that data and notifications were submitted to stakeholders and regulatory agencies when required.

Engagement

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

The service gathered the views and experiences of staff to improve services. The service had recently conducted a consultation with staff to change shift patterns on the unit. Staff that we spoke with were positive about the changes made and the input they had in those changes. From speaking with staff, reviewing minutes of meetings and from our observations, we found that staff at all levels were able to provide feedback and input into the running of the service.

Staff told us the appraisals were a useful process and development was positively encouraged. Staff told us they felt engaged in the day to day operation of the service and could influence change. They had regular staff meetings which they used to share information related to complaint or incidents, for learning and sharing examples of good practice and to provide support to one another.

The service developed a three-year staff engagement strategy, recognising that staff engagement benefits the organisation by creating an informed, involved and productive workplace that help the achievement of the organisation's strategic objectives.

Feedback was sought from patients, relatives and staff about their experiences and their feedback was used to improve the service through shared learning.

See the surgery report for staff survey information on patient and staff satisfaction survey report and findings.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

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

Managers and staff at the service were focused on continuous learning, development, improvement and innovation of the service. This included participating in appropriate research projects and recognised accreditation schemes. The service regularly engaged with staff and families to review how services could be developed and improved.

Improvement was a way to sustain performance and organisational learning. Improvement methods and skills were available, and staff were empowered to lead and deliver change.

Good

Outpatients

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

Are outpatients services safe?

Good

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

Mandatory training

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

Mandatory training for staff covered topics including basic and intermediate life support, manual handling, infection control and prevention, fire safety and medical devices amongst others. We saw that staff compliance of mandatory training ranged between 95% and 100%. The target for mandatory training was 95%.

All staff had access to an online system for training and were given the time to complete the mandatory training. The system was able to give the outpatient manager an overview of performance and gave prompts when staff were due to re-take or refresh their training. The hospital's director of nursing and clinical services could also see mandatory training performance and would send emails to department managers reminding them if any staff were approaching their due dates.

Safeguarding

Staff understood how to protect people from abuse and the service worked well with other agencies to do so.

Staff had training on how to recognise and report abuse, and they knew how to apply it. There were clear safeguarding processes and procedures in place for safeguarding adults and children. The hospital had an up to date safeguarding policy which advised staff what actions to take and which staff member to contact in the event of a safeguarding concern.

At the time of our inspection, 100% of staff were compliant with safeguarding training. All staff we spoke with had received training in levels 2 or 3 for children's safeguarding as appropriate. The lead nurse was trained to level 3 and could access advice from the local council safeguarding teams if required. This met the intercollegiate guidance 'Safeguarding children and young people: roles and competences for health care staff' (January 2019).

Staff were aware of their responsibilities if they identified a woman who had undergone female genital mutilation (FGM). Staff could describe the escalation process if they were to have safeguarding concerns and were aware of the policies and where to find them. The service had a separate FGM policy.

We were told that the service had a comprehensive booklet that highlighted to staff what actions to take in the event of differing safeguarding concerns such as concerns regarding domestic abuse. OPD staff we spoke with were able to articulate to us what they would do in the event of a safeguarding concern. Safeguarding leads were always contactable within the hospital.

Although staff reported they had not had any safeguarding concerns to raise they were aware of the correct pathways to follow to raise their concerns.

Cleanliness, infection control and hygiene

Good

Outpatients

The service controlled infection risks well. Staff kept, equipment and the premises visibly clean. They used control measures to prevent the spread of infection.

All staff we saw at the outpatient clinics were bare below the elbows to prevent the spread of infections in accordance with national guidance.

Hand sanitising gel was available at the main entrance of the OPD centre and in all the consulting rooms. We spoke to patients who told us they saw staff clean their hands before their consultation.

Outpatient staff received infection prevention and control training as part of their mandatory training package. Records indicated that 97% of staff had completed this training. The hospitals' director of nursing and clinical services was the director of infection prevention and control and there was an Infection prevention lead nurse for the hospital. The hospital also had an infection prevention lead nurse.

We checked eight consulting rooms in the outpatient centre and found no concerns. We saw that in all of these rooms, waste was segregated, “I am clean” stickers were used to indicate equipment that was ready to use, hand sinks were available for hand washing and sharps bins were signed and dated in line with best practice.

Personal protective equipment such as gloves and aprons were available, and consumable items were checked and found to be within their expiry dates. We saw appropriate personal protective equipment (PPE) in all of the clinical areas and staff were noted to be using them appropriately. There was good waste and sharps management systems and processes in place. We observed sharps bins correctly assembled, labelled and used correctly.

Curtains in the outpatients department were visibly clean and were dated correctly to indicate when they needed to be changed. Clinical areas in the outpatients department had floor coverings that were wipeable, such as linoleum.

The OPD centre was cleaned in the evening and overnight to minimise disruption to patients and staff during the day when clinics were being held. Cleaning of all medical equipment’s was the responsibility of the nursing and healthcare assistants after each use. The service used ‘I am clean’ stickers to easily identify which pieces of equipment had been cleaned and when.

There were cleaning checklists on the back of clinic rooms in the outpatient centre and in Parkside Suite, and we saw these had daily checks documented. The housekeeping team manager audited the cleanliness of premises on a rotational basis. We saw the most recent outpatient department cleaning audit from December 2018 which scored 96%.

Environment and equipment

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

The design of the environment was appropriate. It was spacious and fully accessible to patients who had additional mobility needs. The service had suitable facilities to meet the needs of patients’ families. There was adequate seating for patients and their families. Emergency call bells were located around the outpatient department.

The service had enough suitable equipment to help them to safely care for patients. This included equipment required to complete patient observations, such as; blood pressure and temperature monitoring and weighing scales. Clinic rooms were equipped with vital signs monitoring devices which were used to carry out patient observations, including machines used for performing electrocardiograms (ECG).

Staff carried out regular safety checks of specialist equipment. This included checks of the patient observation equipment referred to above and emergency equipment such as resuscitation trolleys.

All equipment had asset numbers affixed to them and dates that highlighted when they had been serviced and when they were next due for servicing. All the equipment we saw was in date for servicing and calibration. Fire exits were clearly signposted and visible in appropriate places throughout the department.

There was a reception desk at the entrance to the outpatients centre, with seating for patients and their

relatives, which we noted was manned by two receptionist staff. There were hot and cold drinks facilities for patients and their relatives to help themselves in the outpatients centre.

We were shown a list of all the equipment located in the outpatients department servicing dates. This facilitated the clinic manager to have oversight of all the equipment in their area and ensured that it remained in a serviceable condition for patients use at all times.

The resuscitation trolleys in all outpatients areas were sealed, and all had been checked correctly throughout 2019.

Staff disposed of clinical waste safely and effective systems were in place to ensure this waste was removed from the hospital in an appropriate, safe manner.

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 recognised tools to complete risk screens and assessments for each patient on arrival and updated them when necessary. Staff responded promptly to any sudden deterioration in a patient's health. Staff completed patient observations, such as; blood pressure readings, oxygen saturation readings and patient temperatures to assess and monitor patient's health.

Staff knew about, and dealt with, any specific risk issues. For example, staff were able to access records that showed the risk assessments and management plans for patients who were attending outpatient's post-surgery. This enabled them to check that patients were compliant with post operation risk management advice, such as the use of compression stockings to prevent blood clots. Staff reminded patients of the agreed risk management plans where required and updated risk assessments if changes to risk had been identified.

The staff that we spoke with were able to articulate what to do in the event of an emergency, such as due to a patient's health deteriorating and were able to highlight where the emergency equipment was and how they would summon assistance. All the staff we spoke with during the inspection had attended basic or intermediate life support training depending on their role at the outpatient clinic.

Nurse staffing

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

The service had enough staff of relevant grades to keep patients safe. The service had very low vacancy rates. The outpatients department employed 20 whole time equivalent nursing and assistant nursing staff. In the year prior to our inspection the department had not used any agency nurses to staff the outpatient clinics.

Managers accurately calculated and reviewed the staffing numbers and skill mix needed for each shift and the numbers of staff on all shifts matched the planned numbers. The service had a very low turnover rate. The turnover rate for nursing staff between March 2018 and February 2019 was 1% for all staff group. Sickness rates for nurses were 1% in 2018/19 reporting period. There was minimal use of agency staff.

Staff records showed that appropriate checks were made that ensured they were safe to work with patients. This included requesting and reviewing criminal history checks and references from previous employers.

Senior staff told us they could adjust the number of staff needed to cover the outpatient services to help during busy times, or where patients had greater needs.

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.

The outpatients service was a consultant led service. Consultants who held clinics were responsible for the care of their patients. Administrators and booking staff organised clinic lists around consultants' availability. The

hospital ensured that there was at least one resident medical officer (RMO) to provide 24 hours, seven days per week to provide medical cover in the whole hospital. Staff in the outpatients centre were able to request the attendance of the RMO to attend patients in the outpatients department if required.

There was a medical advisory committee (MAC) responsible for consultant engagement. For a consultant to maintain their practising privileges at the hospital, there were minimum data requirements with which a consultant must comply. These included registration with the General Medical Council (GMC), evidence of insurance, and a current performance appraisal or revalidation certificate. In speaking with the chair of the MAC and the medical director of the service, we were assured this process was followed.

Records

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

The hospital had a mixture of paper and electronic care record. At our previous inspection, there had been incidents where patient notes had been removed from the hospital by consultants which was not in line with best practice. At this inspection, staff told us that this no longer occurred in the outpatient's department.

Electronic records could only be accessed by authorised personnel. Computer access was password protected and staff used individual login details to access patients record. All imaging, histology and blood results were available electronically.

Staff and consultants were not permitted to remove any patient records from the site without prior permission from the registered manager. All consultants were registered with the Information Commissioner's Office as data controllers. A care record audit was completed by the outpatient service in February 2019. The aim of the audit was to assess the quality of patient records within the department. The audit found that all records audited were completed satisfactorily and contained evidence of risk assessments, consent forms and that all entries were legible.

Outpatients staff received information governance training as part of their mandatory training package. We saw that all staff had completed this training.

Medicines

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

The hospital had a safe use of medicines policy which was in date and all staff worked within the parameters of the policy. Senior nurses held the keys to the medicines cupboard which was in line with best practice. We noted that medicines were stored, managed, administered and recorded securely and safely.

We checked medicines in the medicines cupboards and saw that these were all within their expiry dates, and boxes that were close to their expiry date were pulled to the front of the cupboard and had the expiry date highlighted. Medicines that required refrigeration were stored in a locked fridge, keys were held by the senior member of staff and temperatures were checked and recorded daily when the service was open.

Prescription pads were kept in a locked medicines cupboard until they were needed for a consultant clinic.

Incidents

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

The service used electronic incident reporting system which all staff had access to and knew how to complete an incident report. The registered manager was responsible for conducting investigations into all incidents. The registered manager used the incident report to identify any themes and learning and shared these with staff at their team meetings.

Staff we spoke with knew how to report incidents and could give examples of when they would do this.

Good

Outpatients

Managers investigated incidents and shared learning with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

In the period between April 2018 and March 2019 inclusive, the outpatients department recorded a total of 82 incidents. The majority, 32, were communication issues. We observed on the staff notice boards that learning from incidents and actions were shared, such as improving communication with patients.

From April 2018 to March 2019, the OPD did not report any incidents classified as a never event. Never events are serious patient safety incidents which should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Staff we spoke with understood the duty of candour regulation. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff we spoke with said there was a culture of openness in the service. They kept patients informed when clinics were running late and apologised for any delays or errors. The manager told "pro-active and visible".

Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The service had not needed to do this but staff we spoke with were aware of the term and the principle behind the regulation and the need to be open and honest with women where incidents occurred.

Managers were aware of the requirements for reporting incidents and submitting notification to the CQC. However, at the time of inspection the registered manager had not been required to submit any notifications. We observed minutes of meetings where it had been documented that incidents had been discussed along with learning and actions.

All of the staff that we spoke with told us that they were made aware of incidents and subsequent learning and actions via email, as well as the noticeboards and staff meetings.

Are outpatients services effective?

Not sufficient evidence to rate

We do not rate effective; however, we found the following:

Evidence-based care and treatment

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

There were a range of clinical care patient pathway documents for staff to follow which ensured that all patients were consistently receiving evidence-based care for their condition.

Staff followed up-to-date policies and procedures to plan and deliver high quality care according to best practice and national guidance. Policies and procedure guidelines relevant for outpatient services were accessible to staff on computers, stored in a shared document folder and staff could access these on the hospital online portal. The policies we sampled were aligned to national guidance and were in date, with review dates noted.

The outpatient department undertook monthly consent form and hand hygiene audits as part of the regular audit programme. The audit results showed 98% compliance level which was better than the 95% corporate target.

Nutrition and hydration

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

Hot and cold drinks with biscuits were always available in the outpatient areas for patients and their relatives.

Pain relief

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

Patients were asked about their pain at each appointment and were advised appropriately in how to manage this. Clinical staff administered and recorded pain relief accurately.

Consultants assessed patients in their clinics and prescribed pain medication accordingly. Patients received pain medicine for minor procedures performed at the outpatients department.

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 provided evidence of benchmarking against similar organisations on monitoring patient outcomes. The clinical services manager had plans to align the service with a local independent hospital to share best practice and compare outcomes.

The service monitored patient outcomes and experience through their monthly clinic audits and patient satisfaction surveys. There was a good range of local audits within the outpatient department to monitor and report on patient outcomes. Audits included record keeping, patient satisfaction and consent and infection prevention. The audit report showed the department performed better than the hospital target. The service used the audit outcome to improve services further.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and there were processes in place to assess staff competencies and suitability for their role.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Effective recruitment systems were in place to ensure staff were suitably skilled to work in their roles. Outpatient staff were given an induction pack that they worked through as new members of staff. This included information about the OPD structure, opening times, onsite parking and uniform. We spoke with new members of staff who told us how useful their induction to the service was and made them feel valued by the team.

The hospital had an induction policy which outlined that new starters in the department were supported to complete their induction program, and also being familiar with their working environment, only using equipment that they were competent to use and identifying their learning needs. All new starters had a personal development plan agreed with their line manager. All new starters were assigned a buddy, which was an experienced member of staff who they could approach for advice, assistance and support. Staff that we spoke with during our inspection confirmed that this was what happened at the start of their employment in the hospital. New members of staff told us they mostly worked the same shifts as their mentors and buddies if rota and skill mix permitted.

Nursing and allied health professional staff we spoke with confirmed they were encouraged to undertake continual professional development and were given opportunities to develop their skills and knowledge through training relevant for their role. This included completing competency framework for areas of their development and they were also supported to undertake specialist courses. The outpatient's manager appraised staff's work performance and provided additional support to staff if needed.

Managers made sure staff attended team meetings or had access to full minutes of the meetings when they could not attend. This ensured staff were kept updated about changes in practice.

The director of nursing and clinical services monitored the nursing revalidation process and staff were supported in collating their evidence for revalidation. Revalidation is a new process since 2016 where nurses and midwives need to demonstrate to the Nursing and Midwifery Council that they can practice safely and effectively.

Any concerns related to the consultants around their competency was dealt with via the medical advisory (MAC) guidelines. Ongoing compliance with practising privileges was monitored monthly by the MAC.

Multidisciplinary working

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

Good

Outpatients

There was evidence of good team working. Staff felt the small team sizes meant they all got to know each other well and worked well together.

Regular consultant led multidisciplinary team meetings were held to discuss patients treatment. We were told by managers that nursing staff, allied health professionals and managers attended these meetings. Staff told us consultants were approachable and always willing to give help and advice.

We attended the outpatient daily huddle meeting which was attended by the nursing team. The huddle discussed patient care and daily workload for the department.

We heard positive feedback from staff of all grades about the excellent teamwork. Staff worked towards common goals, asked questions and supported each other to provide the best care and experience for the patients.

Seven-day services

The outpatient department did not provide seven-day services.

The department was open 8am to 9pm Monday to Friday and 8am to 2pm and Saturdays.

Health promotion

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

Staff assessed each patient's health and provided support and advice to any individual to live a healthier lifestyle. All patients were asked lifestyle questions and participated in a health assessment to identify any health promotion needs. The service had relevant information promoting healthy lifestyles and support for every patient receiving care at the hospital.

Patients were encouraged to be involved in the planning and delivery of their care as much as was practicable given the nature of the service provided.

Patients who needed extra support were identified during initial assessment. Through the patient safety questionnaire, family members or carers were permitted to accompany patients and provide support during their treatment at the centre.

Consent and Mental Capacity Act

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

Staff told us they were aware of the hospital's consent policy. Consent was sought from patients prior to the delivery of care and treatment. We saw consent documented in the medical records. This showed patients had consented to treatment and knew the expected benefits and risks. A patient, on the day unit, told us the doctor had undertaken the consent process thoroughly and explained the risks and side effects of their procedure. They had been given a copy of the consent form.

Staff also sought consent to share information with the patient's GP. The patient would also receive a copy of any correspondence. A patient commented how useful this was, as it kept them informed as they were often unable to recall all the information given to them during consultations.

The hospital had a policy to guide staff in the correct use and interpretation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff completed these training as part of the mandatory training programme and understood issues in relation to capacity and the impact on patient consent. 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 outpatients services caring?

Good

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

Compassionate care

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

Patients said staff treated them with compassion and kindness. Staff took time to interact with patients and

those close to them in a respectful, dignified and considerate manner. Staff were discreet and responsive when caring for patients. We observed staff treating patients with compassion and respect, showing empathy.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude. For example, patients who disclosed unhealthy life choices, such as; smoking and excessive use of alcohol were shown understanding and were supported and encouraged to seek the relevant support to make lifestyle changes.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. For example, patients who had a carer role were asked additional questions and given specific advice about their own care needs and how this may impact on their carer roles. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for them.

Emotional support

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

Patients told us that they were given enough time during their respective consultations and that they did not feel rushed at all. We observed staff interactions with patients and noted that information and explanations were given to patients in a kind and sensitive manner.

We observed and heard staff speaking with patients in a kind and caring manner. We also observed staff giving reassurance to patients both over the telephone and in person. All staff provided support for the patients and their carers to cope emotionally with their condition, treatment and outcomes.

Patients reported that if they had any concerns, they were given the time to ask questions. Staff made sure that patients understood any information given to them before they left the hospital.

Staff told us a quiet room was available for breaking bad news if required. One staff member told us although they had not been given specific training on breaking bad news, they knew they could always ask for advice and get support from other staff members. They also said if families became distressed following bad news, they felt the team had the skills to deal with the immediate distress. They would access additional psychological support from a counsellor if appropriate.

Understanding and involvement of patients and those close to them

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

We observed and were told by the patients that we spoke with, that patients were given time to ask questions about their care and treatment. We observed staff introduced themselves and communicated well to ensure that patients and their relatives/friends fully understood about their care. Staff spoke with patients sensitively and appropriately dependent on their individual needs and wishes.

Patients we spoke with following a consultation told us that they felt they had been fully informed of upcoming treatments, test results and their next appointment. Staff made sure patients and those close to them understood their care and treatment. Doctors and nurses gave people information about their diagnoses and treatment options and ensured time was allocated for patients and those close to them to ask questions. Questions were then answered in a suitable manner to ensure patient understanding. Staff spoke with patients, families and carers in a way they could understand, using interpreters where necessary.

Are outpatients services responsive?

Good

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

Service delivery to meet the needs of local people

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

Good

Outpatients

The service ran specialised clinics such as the one stop breast clinic and a cancer and gynaecology clinic. All these services were supported by dedicated specialised nurses in each area.

The service had a policy entitled "provision of chaperones during examination, treatment and care. At the reception desk we saw a notice informing patients about the availability of chaperones consultations and examinations and treatment.

There were a variety of patient information leaflets in the reception area for patients to take away.

The facilities and premises were appropriate for the services being delivered. The waiting areas were furnished to a high standard and provided enough comfortable seating. There was a range of free hot and cold beverages available, as well as newspapers and magazines to read.

Clinics ran in the hospital between 8am and 6pm Monday to Friday. This allowed patients who worked office hours during the week to attend at a time that suited them, and we spoke to patients who told us they were able to get appointment times that suited their needs. Staff monitored and acted to minimise missed appointments. Staff ensured that patients who did not attend appointments were contacted and appointments were rearranged.

Meeting people's individual needs

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

Patients we spoke with told us they were offered to have a chaperone during their consultation. Staff were trained to act as chaperone for patients who attended unaccompanied if needed. During our inspection, we noted that patients could have their bloods taken on the same day as the appointment and staff were trained to do this.

The hospital used a translation service to provide care for patients for whom English was not their first language. An interpreter can be booked for a patient when requested.

Patient information leaflets were available to all patients; however, these were all in English. We were told that the leaflets could be translated in patient's language of choice if required.

A range of health education leaflets were available and given to each patient. Some of these were available in other languages and could also be translated if required.

The environment was appropriate and patient-centred with comfortable seating, refreshments and suitable toilets. Patients we spoke with were very positive about the services and told us they received good treatment and were happy to attend the hospital again for further appointments. Other supportive services available to patients included cultural support, psychology, counselling and complementary therapies.

Access and flow

People could access the service in a way and at a time that suited them. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were better than national standards.

Patients could access services and appointments in a way and at a time that suited them. All patients we spoke with told us told us they had arranged their appointments that suited their needs rather than the needs of the hospital. Patients could access the service in a prompt manner. An audit of 100 patients who were referred to outpatients between March 2018 and February 2019 showed that 100% of these patients were offered an initial appointment within 48 hours of their referral to the hospital.

We spoke with six patients and five relatives of patients in the outpatient department and all were very positive about the timeliness and effectiveness of the care they or their partner had received. They said they were "shown compassion and seen quickly".

We observed notice boards in the main outpatients area that highlighted to patients and their relatives what clinics were running and if there was any delay. Patients we spoke with told us that they had not had to wait long to get their appointment and when they arrived at their appointment they were seen promptly.

Good

Outpatients

The referral to treatment data for the hospital showed that at the time of our inspection the service was performing better than the national average of similar service in the independent healthcare sector. The registered manager told us the service averaged 98% referral to treatment target throughout the year.

The service did not need to record waiting times (as required by NHS England) as this requirement applies to NHS funded patients only. However, staff told us that patients were booked within one week and always sooner if urgent. All the patients we spoke with told us it was easy to book a convenient appointment at the hospital. One patient said, 'the appointments are well facilitated around your family schedule.'

We saw staff informed patients of delays on arrival at the OPD centre or if appropriate by phone before scheduled appointments. Patients were given the option to rearrange another appointment at another suitable time if required. None of the patients we spoke with were caused any distress or inconvenience by the delay and the clinic appointments on that day.

Learning from complaints and concerns

People could give feedback and raise concerns about care received. The service treated concerns and complaints seriously and investigated them.

There was an in date complaints policy which highlighted information about the procedure to follow for receiving, recording and investigating complaints. Between March 2018 and February 2019 there were 25 complaints received from patients attending the hospital.

The registered manager had overall responsibility for complaints, however the director of nursing and clinical services led on any complaint investigation where there were concerns about clinical aspects of patient care. The complaints policy stated that all complaints should be acknowledged within two days and responded to within 20 working days. No complaints were referred to the ombudsman or Independent Healthcare Sector Complaints Adjudication Service in the last 12 months. We saw comments and formal complaints leaflets and information on how to complain available in the waiting room areas.

Are outpatients services well-led?

Good

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

Leadership

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

The outpatient manager worked across two sites of the hospital. There was an outpatient sister in charge at each site. The outpatient manager reported to the registered manager and the director of nursing and clinical services.

We noted that members of the senior management team were visible in the OPD centre. Staff told us they felt well supported by the director of nursing and clinical services, a manager, band 6 sisters and lead OPD nurse who were always around.

We were told a senior nurse in charge was available as a contact point for staff, consultants and patients, and was available via bleep or telephone. All the staff that we spoke with during the inspection were extremely positive about the leadership in the outpatients department.

Vision and strategy

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

Staff that we spoke with during the inspection were aware of the hospitals vision and strategy. The overarching strategy was to "help individuals to achieve, maintain and recover to the level of health and wellbeing they aspire to by being a trusted provider and partner". Whilst there were no additional visions or strategy for the outpatient's services, we spoke with managers who described growing and improving their services.

The registered manager described that since being in post they had tried to ensure outpatient staff were more outpatient focussed, rather than being an additional service. Staff we spoke with confirmed that they felt the focus in their department had changed and was more focussed on them working in their own department.

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.

The leadership team told us that there was an open culture where all staff could discuss ideas and concerns. Staff we spoke with told us their leaders and supervisors were always visible and approachable and that they could approach them and be listened to about suggested changes or a concern.

OPD staff told us they felt supported as individuals in their roles but also as part of the wider hospital team. Examples of this included support being offered to staff from other departments, and staff from different roles working together to achieve their outcomes. Healthcare assistants reported being well supported by nursing colleagues, and housekeeping staff spoke of being supported by administrative staff and other colleagues. Staff described the culture being an improvement from previous roles they had worked in and feeling happy to be part of the hospital.

Many staff told us they loved working at the hospital and were proud of what they could achieve individually and collectively as a team. There was a strong sense of teamwork. We saw evidence that the culture of the services was centred on the needs of the patient. Many staff described how the patients' experience of the service was paramount.

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 senior management team functioned effectively and interacted with each other appropriately. There were clear governance structures in place where a number of committees, such as; the health and safety committee, the medicines management committee and the infection prevention committee fed into the quality and safety committee which in turn reported directly to the board.

Board meeting minutes showed they had oversight of the service's performance against quality and safety measures. We saw that they were aware of areas that required improvement, such as compliance with some mandatory training topics and how to address communication issues in dealing with patients' enquiries and concerns.

Team meetings were facilitated regularly, and we saw minutes from several of these meetings which were well attended by a variety of outpatient staff. All highlighted clear action plans assigned to a particular staff member. We observed minutes of the monthly outpatients team meetings at which all team members were invited to attend. Items discussed on the agenda were audits, incidents, training, medicines and risk and governance.

We observed staff noticeboards in all staff areas highlighting to staff the current departmental risk register, minutes from the recent safety huddles and team successes such compliments and staff of the month award.

Partnerships, joint working arrangements and shared services were clearly set out through service level agreements (SLA's). Staff understood their roles and accountabilities under these SLA's and to and to whom they should report.

There was a practicing privileges policy that outlined the requirements the consultants needed to follow and meet to maintain their practicing privileges. This included annual submission of insurance, appraisal and a formal two-yearly review of their practicing privileges by the Medical Advisory Committee (MAC). We reviewed a

selection of consultant files and these contained evidence qualifications, insurance, registrations and appraisals. This showed that this staff group were suitably skilled and competent to deliver care and treatment.

Managing risks, issues and performance

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

The leadership team used systems to monitor and manage performance effectively. This included safety thermometer data and compliance with agreed quality improvement goals, such as; ensuring staff gave appropriate health promotion advice to patients who smoked. Feedback about performance was shared appropriately with staff to thank them for their work and/or share plans for improvement.

Performance issues were escalated to the appropriate committees and the board through clear structures and processes. This included concerns about individual staff where records showed that concerns were appropriately reported, managed and investigated to protect patients from any risks associated with poor or unsafe performance.

Clinical audit processes functioned well and had a positive impact on quality governance, with clear evidence of action to resolve concerns. We saw that a number of audits were completed in outpatients by staff and the provider. This included; medicines audits, records audits and provider led quality assurance visits based on the CQC five key enquiry questions (safe, effective, caring, responsive and well-led). The audit showed 96% compliance rate, this meant the service was providing safe.

There was an effective and comprehensive process to identify, understand, monitor and address current and future risks. Staff knew how to identify and escalate relevant risks and issues and identified actions to reduce their impact. A risk register for the service was maintained that incorporated into the hospital's risks, and this was fed into an overall provider risk register and which had oversight from the board. The risks on the register matches the risks we found on the inspection.

Managing information

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

The registered manager informed us they were General Data Protection Regulation (GDPR) compliant and took into consideration Caldicott principles when making decisions on how data protection and sharing systems operated in the hospital. We were told by the registered manager that all staff had completed data protection training as part of their mandatory training. This meant the service was compliant with the commercial third parties information governance toolkit published by the Department of Health which says, all staff should have training on information governance requirements.

Outpatient records were a mixture of paper and electronic based and were stored securely on site, or at an archive site in a different location. The system for preparing records for clinic was managed by the consultant secretaries in conjunction with the medical records staff. At our previous inspection, consultants took patient notes off-site, which was not secure or in line with the hospital policy. At this inspection, we were assured that this practice had stopped.

Information governance, general data protection regulation, internet, email and social media and cyber security were part of mandatory training. Data provided showed 100% compliance of outpatient staff with this training.

Patients consented for the service to store their records. This was part of their signed agreement within the form detailing the type of cancer treatment they were undergoing. This demonstrated the service's compliance with the General data protection regulation (GDPR) 2018.

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. There was sufficient information technology equipment for staff to work with across the service.

Engagement

Good

Outpatients

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

The hospital participated in audits such as the patient satisfaction survey and Patient Led Assessments of the Care Environment. The outpatient department also ran a patient feedback survey and the response rates at the time of our inspection was around 98% rate.

The outpatient team met once a month for team meetings and also had ad-hoc meetings when needed. We saw minutes from these meetings that had a standard agenda and staff had the opportunities at the end of these meetings to raise concerns, issues or updates.

OPD managers attended managers meetings with managers from other hospitals. For example, the outpatient manager had attended groups manager meeting and shared minutes of the meeting with staff. The management team and other leaders consistently engaged with the staff through a variety of communication methods to ensure their views on care and treatment were obtained and they were updated about best practice and changes to policies and processes.

The registered manager and the director of nursing and clinical services held regular mornings meetings where members of staff were invited to attend to promote communication and staff engagement. Staff told us about the reward and recognition programme and how success was often celebrated with the 'employee of the month' scheme.

Learning, continuous improvement and innovation

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

Staff were supported to access specialist training to develop their skills and improve patient care. This included training in; leadership, management and gender re-assignment courses. Staff were empowered to find creative and innovative solutions to improve patient care.

Good

Diagnostic imaging

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

Are diagnostic imaging services safe?

Good

This is the first time we inspected this domain. We rated it as **good.**

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Mandatory training for staff covered topics including manual handling, fire safety and basic life support. Staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. We saw that staff compliance of mandatory training ranged between 95% and 100%. The target for mandatory training was 95%.

All staff had access to an online system for training and were given the time to complete the mandatory training. The system was able to give the diagnostic imaging manager an overview of performance and gave prompts when staff were due to re-take or refresh their training. The manager monitored mandatory training and alerted staff when they needed to update their training. Staff could access training online and face to face training was available for basic life support, manual handling and fire awareness.

In addition to this, staff in the imaging department received appropriate training in the regulations, radiation risks, and use of radiation. We saw that staff had read and signed the local rules and policies which comes under the ionising radiation regulations.

Safeguarding

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

The imaging department had processes in place to ensure the right person gets the right radiological scan at the right time. We saw the service checked three points of identification and used 'pause and check'. Pause and check is an initiative used in radiology departments to ensure the patients identity is carefully checked so that the right person gets the right radiology, and ensures patients are not unnecessarily exposed to radiation.

There were clear safeguarding processes and procedures in place for safeguarding adults and children. The hospital had an up to date safeguarding adults' policy which advised staff what actions to take and which staff member to contact in the event of a safeguarding adult concern.

At the time of our inspection, 100% of staff were compliant with safeguarding training. All staff we spoke with had received training in levels two or three for children's safeguarding as appropriate. Any staff member involved in treating children was trained to level three. The lead nurse was trained to level three and could access advice from the local council safeguarding teams if required. Staff had access to colleagues within the hospital who had been trained to level four. This met the intercollegiate guidance 'Safeguarding children and young people: roles and competences for health care staff' (January 2019).

Staff were aware of their responsibilities if they identified a woman who had undergone female genital mutilation

(FGM). Staff could describe the escalation process if they were to have safeguarding concerns and were aware of the policies and where to find them. The service had a separate FGM policy.

Although staff reported they had not had any safeguarding concerns to raise they were aware of the correct pathways to follow to raise their concerns.

Cleanliness, infection control and hygiene

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

All areas in in diagnostic services were visibly clean and had suitable furnishings which were clean and well-maintained. We saw that 'I am Clean' stickers were used on all pieces of equipment on the medical ward. This meant that inspectors were able to see when the equipment had last been cleaned.

Housekeeping staff cleaned the imaging department daily and followed a daily check sheet. We viewed cleaning records which were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning schedules were in place in each clinic room, and housekeeping staff signed the schedule when the room was last cleaned. Deep cleaning of clinic rooms was completed once a month and when infectious patients were treated.

Staff followed infection control principles including the use of personal protective equipment (PPE). During our inspection there were no infectious patients who were being scanned. However, staff told us that if there was an infectious patient they would place them at the end of the list and the room would then be deep cleaned afterward.

There was sufficient access to hand gel dispensers, handwashing, and drying facilities. Hand washing basins had a sufficient supply of soap and paper towels. Services displayed signage prompting people to wash their hands and gave guidance on good hand washing practice. Personal protective equipment such as disposable gloves and aprons were readily available in all areas.

Staff followed the hospital infection prevention and control policy, they were bare below the elbow and used hand sanitisers appropriately. We saw all staff adhering to good hand hygiene policy.

Staff disposed of clinical waste safely. Clinical and domestic waste bins were available and clearly marked for appropriate disposal. We noticed information explaining waste segregation procedures and waste segregation instructions. We saw that there were appropriate cleaning procedures for ultrasound probes following an intimate examination.

Environment and equipment

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

The hospital's diagnostic department was located in three areas. The main hospital housed an MRI scanner, a CT scanner, and general x-ray. The Lodge housed an MRI used for extremities, as well as a DEXA scan. In outpatients there were 3 CT scanners and a new mammoscanner, which was part of the one stop breast clinic.

During our inspection we saw that resuscitation trolleys were available in all diagnostic areas including outpatients, The Lodge, and the main hospital. Staff we spoke to knew where to find the trolleys. We saw that there were resuscitation 'grab bags' in all of the scanning rooms, including ultrasound, x-ray, CT and MRI. This meant that staff had emergency equipment at hand while the trolley was being obtained.

We saw that there was restricted access to all areas with ionising and non-ionising radiation. Rooms could only be accessed using an electronic swipe card. Warning signs were in use throughout the departments, for example we saw sign saying 'strong magnetic field' outside the MRI. We saw that warning lights were used to let staff and public know that a room was 'in use' so that the room was not entered unnecessarily, and people accidently exposed to radiation.

During our inspection we checked the service dates for equipment, including scanners. All the equipment we checked was within the service date. All non-medical electrical equipment was electrical safety tested. Backup

generators were available and were tested on a planned schedule early in the morning to ensure patient scanning was not affected. Staff told us that some equipment such as the CT scanner would be able to function for 20 minutes without the backup generators.

We saw that personal protective equipment was available and used by staff and carers when needed. For example we saw that lead aprons and lead screens were available to protect staff from exposure to radiation.

Staff had enough space to move around the scanners and for scans to be carried out safely. During scanning all patients had access to an emergency call alarm and ear plugs. Patients could also speak to the radiographer through a microphone. We saw that they wore radiation monitors where appropriate.

We saw that The Lodge had undergone a recent refurbishment, and now included five treatment rooms. Staff told us that the MRI scanners at The Lodge were coming to their 'end of life stage. Management tod us the scanners were likely to be out of date by the end of next year. We were told there were plans in place to replace the aging scanners in the new calendar year. We were told a mobile MRI scanner would be used while the scanners were being replaced.

During the inspection we saw that cleaning chemicals subject to the Control of Substances Hazardous to Health Regulations 2002 (COSHH) were stored in a locked cupboard. Waste management was handled appropriately, with different colour coding for general waste, and clinical waste. All clinical bins were seen to be operated with lids and were not overfilled. Waste management and removal including those for contaminated and hazardous waste was in line with national standards.

Oxygen tanks were stored securely and were in date. We inspected two sharps bins and found them to be correctly labelled and not filled above the maximum fill line. We saw that the department had non-magnetic portable fire extinguishers which would not damage scanning equipment.

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 assessed patient risk and developed risk management plans in accordance with national guidance. For example, the service had safety questionnaires that patients completed before they underwent radiological testing.

The department used a magnetic resonance imaging patient safety questionnaire. Risks were managed positively and updated appropriately to reflect any change in the patient's condition including managing a claustrophobic patient. For radiological examinations requiring contrast (dye), patients completed a questionnaire to identify if they had any renal problems which may prevent them receiving contrast. Any known patient allergies were noted on a patient's record.

Patient referrals were checked at the point of referral for any potential safety alerts that required further investigation. For example, whether the patient had any implants or medical devices such as pacemakers.

The service had two permanent radiographer staff members who provided a radiation protection supervisor role. This meant that they had received additional training in the Ionising Radiation Regulations 2017 and were responsible for ensuring compliance with the regulations and the local rules.

During the inspection we saw there was signage outside of the scanning rooms which identified radiation risks and indicated when scanning was in progress. We observed posters in waiting areas which provided patients with information about pregnancy and diagnostic imaging. Staff told us that individual risk assessments for members had been completed, including those who were pregnant.

Staff knew how to respond to any sudden deterioration in a patient's health. There was an emergency button in all rooms in the department which staff could press for assistance from the crash team. A resident medical officer was on site 24 hours a day and could be called upon for assistance. Staff told us that if a patient deteriorated, they would call the emergency team and 999 to transfer the patient to a local NHS hospital.

Good

Diagnostic imaging

Staffing

The service had enough allied health professional 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.

The service had enough staff of relevant grades to keep patients safe. The imaging lead calculated and reviewed the number of radiographers and healthcare assistants needed for each shift in accordance with national guidance. We were told that at the time of our inspection there was only one vacancy within the department, and that was the interim managers radiographer post. We saw that there was one bank radiographer at the time of the inspection. They told us that they receive a full induction to ensure they understood the service. Staff we spoke with told as they department most definitely had enough staff.

Medical Staffing

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

The hospital ensured that there was at least one resident medical officer (RMO) to provide 24 hour, seven days per week to provide medical cover in the whole hospital. Staff in the diagnostic department were able to request the attendance of the RMO to attend patients in the diagnostic department if required.

There was a medical advisory committee (MAC) responsible for consultant engagement. For a consultant to maintain their practising privileges at the hospital, there were minimum data requirements with which a consultant must comply. These included registration with the General Medical Council (GMC), evidence of insurance, and a current performance appraisal or revalidation certificate. In speaking with the chair of the MAC and the medical director of the service, we were assured this process was followed.

Records

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

The hospital used paper records to record patient needs, care plans and risk assessments. All patient records for the radiology department were scanned and kept on an electronic information system. Letters were sent to a patient's general practitioner (GP) with information around the outcome of scans.

We reviewed four sets of patient records and referral forms and found that they were comprehensive and detailed. Patients completed a safety consent checklist form consisting of the patients' answers to safety screening questions and also recorded the patients' consent to care and treatment. Referral forms included a detailed set of safety questions such as whether the patient had any allergies, whether the patient was diabetic and whether the patient had a pacemaker. The referral form also included a section to be signed by a chaperone, comforter or carer which checked that the person accompanying the patient was not pregnant. The form also flagged any phobias the patient had so a suitable appointment length could be arranged where the patient could spend time familiarising themselves with the scanner room before starting their procedure.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The hospital's pharmacy team provided guidance and support to the imaging department regarding all issues related to medicines management. Staff told us they could contact the pharmacist if had any concerns regarding medicines patients were taking.

Patients received a letter prior to their procedure advising them to continue with their usual medicines regime. All patient allergies were documented and checked on arrival at the hospital. When contrast was used, batch numbers were recorded in a patient record.

The service used contrast media (dye) which are chemical substances used in some MRI scans. Medicines were

Good

Diagnostic imaging

stored in locked rooms and access was restricted to authorised staff only. There were no controlled drugs in the department. We checked a sample of medicines and found they were in date.

Room temperatures and fridge temperatures were recorded on a daily basis. We checked the drugs fridge temperature and ambient room temperature during our inspection and found them to be within expected range.

Incidents

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

Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. They used an electronic incident recording system that allowed to capture incidents, track any actions taken in response and provide relevant staff with feedback.

The service did not report any never events during the past 12 months prior the inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Staff told is there was a strong incident reporting culture, and feedback was provided to staff that reported incidents. We saw that significant events were also highlighted in the operational huddles. Staff we spoke to felt there was a learning culture and that they could raise issues without worrying about repercussions.

When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service had a policy which described the duty of candour process. Staff we spoke to, understood the duty of candour requirement and its implication to clinical practice. Staff could give examples of when duty of candour had been applied in the diagnostic department.

Are diagnostic imaging services effective?

Not sufficient evidence to rate

We do not rate effective in diagnostic imaging services

Evidence-based care and treatment

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

Staff used the Society and College of Radiographers 'pause and check' system which was a six-point check to help combat errors that attributed to incidents. Checks included demographic checks to correctly identify the patient, as well as checking with the patient the site/side to be imaged, the existence of previous imaging and for the operator to ensure that the correct imaging modality is used.

Care and treatment were delivered and clinical outcomes monitored in accordance with guidance from the National Institute for Health and Care Excellence (NICE). NICE guidance was followed for diagnostic imaging pathways as part of specific clinical conditions. We saw also posters with exposure guidelines in control rooms.

Guidance was provided by the Ionising Radiation (medical exposure) Regulations (IR(ME)R) for the safe use of radiological equipment. This included guidance for operating procedures, incident reporting, training and equipment maintenance, and medical physics' role. These (IR(ME)R) procedures were accessible to all staff on the hospital intranet.

Good

Diagnostic imaging

Staff assessed patients' needs and planned and delivered patient care in line with evidence-based, guidance, standards and best practice. For example, staff followed the MHRA safety guidelines for magnetic resonance imaging equipment in clinical use.

Nutrition and hydration

The service assessed people's nutrition and hydration needs. The service made adjustments for patients' religious, cultural and other needs.

Patients awaiting their appointment had access to drinking water and a tea and coffee machine which was free of charge in the patient waiting area.

If clinics were running late, and for patients who were not under fasting instructions, staff signposted patients to the hospital's restaurant for hot and cold food options or the snack kiosk for refreshments.

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 consultants were able to prescribe pain relief in line with individual needs and best practice. Patients were asked to describe their pain with a score of zero (no pain) to ten.

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 not been accredited under relevant clinical accreditation schemes.

The radiology department conducted an internal quality audit four times per year. Results were discussed with the radiologist and fed back to staff.

Managers used information from the local audits to improve care and treatment. The service had a programme of audit to check the quality of procedures and the safety of the service. The service had a clinical audit schedule and audited individual areas including, imaging medicines management, World Health Organisation (WHO) five steps to safer surgery checklist, patient documentation, picture and archiving service (PACS) system and imaging in theatres.

The Radiation Protection Officer (RPA) (a specialist in radiation safety and compliance matters which relevant organisations must have by law) conducts regular audits, and has found that the department is compliant in radiation safety.

The hospital did not participate in the Improving Quality in Physiological Services (IQIPS) accreditation scheme.

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. Effective recruitment systems were in place to ensure staff were suitably skilled to work in their roles. All radiographers were registered with the Health and Care Professions Council (HCPC) and met HCPC regulatory standards to ensure the delivery of safe and effective services to patients.

The hospital had an induction policy which outlined that new starters in the department were supported to complete their induction program, and also being familiar with their working environment, only using equipment that they were competent to use and identifying their learning needs. Staff we spoke with told us they were encouraged to undertake continual professional development and were given opportunities to develop their skills and knowledge through training relevant to their role.

Staff received in-house radiation protection training and were encouraged to attend conferences and take on development opportunities such as attending management courses and national radiology management conferences.

The hospital reported 78% of contracted nursing, healthcare assistants and allied health professionals' staff were appraised in 2018/2019 and all the medical staff. Managers showed us that in diagnostic imaging, all members of staff had received their appraisals.

Good

Diagnostic imaging

Multidisciplinary working

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

Throughout the inspection we saw evidence of good multidisciplinary working in all areas. We saw evidence of good working relationships between nurses and medical staff. We saw positive relationships between radiographers and the administrative team. Administrative staff told us they worked well with radiographers and felt comfortable asking questions or queries relating to referrals. Healthcare assistants told us consultants were friendly and approachable. Radiographers told us they had good relationships with radiologists and could contact them at any time.

We observed positive interaction and respectful communication between professionals. The hospital had good relationships with other external partners and undertook scans for local NHS providers and private providers of health insurance schemes.

Seven-day services

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

The diagnostic and imaging department was open 8am to 8pm, Monday to Friday. In addition to this, MRI services were available seven days a week, and CT scans were also available on Saturdays.

Staff told us that the service also operated an on-call rota from home seven days per week for both urgent CT, MRI and x-ray requirements.

During the inspection, we saw that appointments were flexible to meet the needs of patients, and that appointments were available at short notice.

Breast clinics were available Monday to Friday and included a 'one stop' clinic where patients could have a mammogram, ultrasound, biopsy and see the consultant all on the same day.

Health promotion

The imaging department displayed information and advice to encourage patients to lead healthier lives.

There was information on diagnostic imaging procedures available in the patient waiting area. During the inspection we saw information leaflets and posters displayed in the waiting area about what would happen during a scan, what preparation was required prior to a scan and self-care advice following a scan.

Consent and Mental Capacity Act

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

Staff we spoke with understood the requirements of the Mental Capacity Act 2005. Staff completed mandatory training on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff training for the Mental Capacity Act was incorporated within the consent module. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

During the inspection we saw that staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff we spoke with understood the need for consent and gave patients the option of withdrawing consent and stopping their scan at any time. The service used consent forms that all patients were required to sign at the time of booking in at the service. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records.

Are diagnostic imaging services caring?

Good

This is the first time we rated this domain. We rated it as **good.**

Compassionate care

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

Good

Diagnostic imaging

Staff promoted privacy and patients were treated with dignity and respect. We saw staff ensuring the inpatients being taken for scans were covered with blankets. Patients we spoke with told us they were treated with dignity and respect.

Patients were greeted by the reception staff on arrival and informed where they should wait. We observed that the reception staff-maintained patient's privacy at the reception desk. All patients and their families we spoke with were happy with the care they had received and were complimentary about the staff. We observed staff being polite, courteous and friendly with patients.

Patients had designated changing rooms and were provided with gowns while having their scan. In nuclear medicine, a privacy screen could be put up so patients could change in the scanning room so they did not need to walk to the scanner in their gowns. In mammography, staff told us patients could change in the scanning room and explained that they would leave the room to allow the patient some privacy to change into their gowns.

The service had an up to date chaperone policy. Patients were asked at the time of booking if a chaperone was required. There were posters in the department informing patients on requesting a chaperone.

Emotional support

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

Staff supported people through their scans, ensuring they were well informed and knew what to expect. Staff provided reassurance and support for nervous, anxious, and claustrophobic patients. They demonstrated a calm and reassuring attitude so as not to increase patients' anxiety. Staff described how they would provide ongoing reassurance throughout a scan and updated the patient on how long they had been in the scanner and how long was left.

Staff told us that if patients expressed concerns or fears around procedures and scans, they took the time to explain how scans were undertaken and would ask the patient to come in a bit earlier so they could see the scanner machine. For patients who had a fear of enclosed spaces, staff asked patients to come in to the department before their appointment, so they could see the scanner, the room and try lying in the scanner to see if they were comfortable in the space.

Understanding and involvement of patients and those close to them

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

We observed good rapport between staff and patients and staff displayed good listening skills.

Staff involved patients and those close to them in decisions about their care and treatment. Patients told us they felt comfortable asking consultants, nurses and radiographers questions and felt involved in their treatment plans.

Staff recognised when patients or relatives and carers needed additional support to help them understand and be involved in their care and treatment. Staff enabled them to access this, including access to interpreting and translation services.

Staff worked with patients and their families to promote their understanding and empowered them to play an active role in their treatment and care. Staff showed us leaflets which patients took home with them after their scan which informed them aftercare advice and any potential reactions they could have to contrast that was given and what to do, who to contact in the event of such reactions.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There was comment box in the waiting areas.

Are diagnostic imaging services responsive?

Good

This is the first time we inspected this domain. We rated it as **good.**

Service delivery to meet the needs of local people

Good

Diagnostic imaging

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

The diagnostic imaging department provided a range of services such as general X-ray imaging, interventional and diagnostic ultrasound, digital full field mammography, computerised tomography (CT), magnetic resonance imaging (MRI), radiographic imaging in theatre, CT/ nuclear medicine, fluoroscopy and dexa scanning. The service operated from Monday to Friday 8am to 8pm. On Saturdays, general X-ray and ultrasound was open from 8am to 2pm and MRI scanning operated from 8am to 8pm on Saturday and Sunday. For inpatients, there was access to 24-hour diagnostic imaging on site. The hospital also had access to an on-call radiographer.

The facilities and premises were appropriate for the services that were planned and delivered. There were toilets, changing rooms and drinks machines for patients. Car parking on the premises was free of charge.

Information was provided to patients before their appointments. Appointment letters contained information such as contact details, directions to the department and information about any tests or intervention including if samples or preparation such as if fasting was required. Patients could request to receive appointment reminders by text or phone call. All patients were able to choose an appointment date and the service offered flexible appointment times to all patients.

At the time of our inspection, there was no waiting list for diagnostic imaging.

Meeting people's individual needs

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

Services were planned to take account of the needs of different people. Staff received training in equality and diversity and had a good understanding of cultural, social and religious needs of patients and demonstrated these values in their work. Patients with reduced mobility could easily access the imaging departments which were on the ground floor of each building. The corridors were wide enough to accommodate wheelchairs.

Staff told us they could arrange interpreting services to support patients and their families whose first language was not English. Staff confirmed that it was easy to book interpreting services which could be arranged face to face, or by telephone. Interpretation services were made available to the staff through a service level agreement with an external company. Interpretation requirements were identified at the point of booking. Staff told us they checked with patients if they required a male or female interpreter, which showed staff were aware of the potential religious or cultural needs of the patient.

The department had a hearing loop available for patients who had a hearing impairment. There was a sign at the reception desk notifying patients of the portable induction loop system available.

We observed staff introduced themselves and communicated well to ensure that patients and their relatives/friends fully understood about their care.

Access and flow

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

All referrals were triaged by radiographers who reviewed and confirmed patient suitability for scans. Patients were given a choice of appointment times that they could arrange to suit their schedules. All patients who were referred for diagnostic imaging were given appointments within 48 hours of the request being made and this was monitored at the daily huddle meeting. Patients who required X-rays could have them performed on the day of referral.

At the time of our inspection, there were no waiting lists for patients to attend radiology. Patients told us that they were mainly seen on time or within 10 minutes of their appointment. Staff told us that patients were always informed of any delays, and we observed this during the inspection.

Good

Diagnostic imaging

The radiology department and a breast surgeon operated a 'one stop clinic', where patients could have a consultation, mammogram and ultrasound with options for additional interventional procedures, such as a biopsy, if required – all during one appointment.

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.

During the inspection we saw that there was an in-date complaints policy which highlighted information about the procedure to follow for receiving, recording and investigating complaints. The hospital told us that between March 2018 and February 2019 there were no complaints received from patients attending the hospital.

The registered manager had overall responsibility for complaints, however the director of nursing and clinical services led on any complaint investigation where there were concerns about clinical aspects of patient care. The complaints policy stated that all complaints should be acknowledged within two days and responded to within 20 working days. No complaints were referred to the ombudsman or Independent Healthcare Sector Complaints Adjudication Service in the last 12 months.

We saw comments and formal complaints leaflets and information on how to complain available in the waiting areas.

Are diagnostic imaging services well-led?

Good

This is the first time we inspected this domain. We rated it as **good.**

Leadership

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

At the time of our inspection there was an interim diagnostic department manager in post, who had been seconded into the position from being a radiographer. The diagnostics manager reported to the registered manager and the director of nursing and clinical services.

During the inspection we saw that members of the senior management team were visible in all diagnostic areas. Staff told us they felt well supported by the director of nursing and clinical services, manager, consultants, radiographers, nursing staff, and clerical staff. We were told a senior radiographer as well as the manager were available as a contact point for staff, consultants and patients and was available via bleep or telephone. Leaders we spoke to were able to clearly articulate the priorities and risks present in the service.

All the staff that we spoke with during the inspection were extremely positive about the leadership in the diagnostics department, and told us they had been offered opportunities to develop their skills through external courses and conferences.

Vision and strategy

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

During the inspection we saw that the overarching hospital strategy was to "help individuals to achieve, maintain and recover to the level of health and wellbeing they aspire to by being a trusted provider and partner". Staff that we spoke with during the inspection were aware of the hospitals vision and strategy.

Whilst there were no additional visions or strategy for the diagnostic imaging services, we spoke with managers who described growing and improving their services.

There were plans to refurbish parts of the hospital to improve patient experience. Staff we spoke with knew about plans to refurbish areas of the hospital. Staff in the

imaging department were aware of plans to replace the MRI scanner next year. Staff had been involved in this decision by looking at new scanners together and visiting other sites.

Culture

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

All staff we spoke with told us the culture of the department had improved since the appointment of the interim manager, and that they felt respected, supported and valued. Staff told us that the leaders and supervisors were always visible and approachable and that they felt they could approach them and be listened to about suggested changes or a concern. The leadership team told us that there was an open culture where all staff could discuss ideas and concerns.

Staff told us they felt supported as individuals not only in their roles but also as part of the wider hospital team. Examples of this included support being offered to staff from other departments, and staff from different roles working together to achieve their outcomes.

Many staff told us they loved working at the hospital and were proud of what they could achieve individually and collectively as a team. There was a strong sense of teamwork. We saw evidence that the culture of the services was centred on the needs of the patient. Many staff described how the patients' experience of the service was paramount.

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 senior management team functioned effectively and interacted with each other appropriately. There were clear governance structures in place where a number of committees, such as; the health and safety committee, the medicines management committee and the infection prevention committee fed into the quality and safety committee which in turn reported directly to the board.

Local governance processes were achieved through monthly team meetings. Diagnostic imaging team meetings were held monthly. During the inspection, we viewed the meeting minutes which showed that the meeting discussed mandatory training performance, incidents and lessons learned, complaints and feedback, risk register, safeguarding, audits and action plans, and actions arising from the meeting.

We observed staff noticeboards in all staff areas highlighting to staff the current departmental risk register, minutes from the recent safety huddles and team successes such compliments and staff of the month award.

Partnerships, joint working arrangements and shared services were clearly set out through service level agreements (SLA's). Staff understood their roles and accountabilities under these SLA's and to and to whom they should report.

There was a practicing privileges policy that outlined the requirements the consultants needed to follow and meet to maintain their practicing privileges. This included annual submission of insurance, appraisal and a formal two-yearly review of their practicing privileges by the Medical Advisory Committee (MAC). We reviewed a selection of consultant files and these contained evidence qualifications, insurance, registrations and appraisals. This showed that this staff group were suitably skilled and competent to deliver care and treatment.

Managing risks, issues and performance

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

The imaging department kept its own risk register which was maintained by the imaging clinical services. Risks on

the risk registers were reviewed regularly and discussed at clinical governance meetings, heads of department meetings and team meetings. Each risk was given a rating, review date, and set of control measures.

The issues and risks which managers identified were in line with what we found on inspection and there was alignment between these and the risks outlined on the risk register, for example on risk for the imaging department included the age of equipment which was due for replacement, for which there were plans in place.

There was a formal audit plan in place in the imaging department which outlined the frequency of the audits and dates of the audits. Audit results were fed back at the clinical governance meetings, heads of department meetings as well as discussed at team meetings.

Performance issues were escalated to the appropriate committees and the board through clear structures and processes. This included concerns about individual staff where records showed that concerns about individual staff members were appropriately reported, managed and investigated to protect patients from any risks associated with poor or unsafe performance.

Managing information

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

There were effective arrangements to ensure the confidentiality of patient identifiable data. During the inspection we saw paper referral forms that were brought in by patients were placed face down in a tray at reception so that patient identifiable data could not be seen. Paper based patient records were stored securely and electronic information was only accessible by authorised staff members.

During the inspection we saw there were computer stations throughout the department. Staff told us there were sufficient numbers of computers to access when they needed. We observed staff logging off after using computers.

We saw that information from scans were sent to referrers to give timely advice and interpretation of results. Staff told us they could also request access to previous patient images and could add images to NHS patient records to ensure patients received continuity of care in imaging.

We saw that heads of department and the senior management team monitored quality and risk information at clinical governance meetings where audit results, risks and incidents were discussed.

We were told by the registered manager that all staff (100%) had completed data protection training as part of their mandatory training. This meant the service was compliant with the commercial third parties information governance toolkit published by the Department of Health which says, all staff should have training on information governance requirements. Information governance, general data protection regulation, internet, email and social media and cyber security were part of mandatory training.

Engagement

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

During the inspection we saw that the hospital participated in audits such as the Friends and Family test and Patient Led Assessments of the Care Environment. The hospital monitored feedback from Friends and Family Test (FFT) results. FFT comments were discussed at huddle meetings and team meetings.

Staff told us there were a number of events that were held for staff to take part in to focus on their wellbeing such as pilates sessions. There was also an occupational health advice line that staff could utilise.

Staff were engaged in the planning and delivery of the service. Staff told us that they felt able to suggest new ideas to their managers and that they were listened to. Staff we spoke with knew of future plans of the service such as the replacement of the MRI scanner in the new year.

The management team and other leaders consistently engaged with the staff through a variety of

communication methods to ensure their views on care and treatment were obtained and they were updated about best practice and changes to policies and processes.

The registered manager and the director of nursing and clinical services held regular mornings meetings where members of staff were invited to attend to promote communication and staff engagement. Staff we spoke with also told us about the reward and recognition programme and how success was often celebrated with the 'employee of the month'.

Learning, continuous improvement and innovation

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

Staff we spoke with were committed to continuous learning. Staff told us they were supported by their managers to develop their leadership skills and access development opportunities. Staff told us since the change in management, they have been able to access additional courses and were encouraged to attend conferences and management courses.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure all patients clinical records are always completed comprehensively.
- The hospital should consider undertaking work to support embedding of surgical safety checks amongst its staff, in line with the guidance issued by the World Health Organisation.
- The hospital should ensure all five steps to safer surgery advocated by the National Patient Safety Agency (including briefing and debriefing; NPSA is now part of NHS Improvement) were undertaken correctly by theatre teams.
- The provider should ensure all staff completes mandatory training.
- The provider should ensure there is sufficient and consistent number of staff to provide support as directed by patient's clinical needs and risk assessments.
- The provider should ensure individual VTE assessments are undertaken within 24 hours of admission.
- The provider should ensure all staff are regularly appraised and when required undergo regular practicing privileges review.
- The provider should ensure all five steps to safer surgery check list advocated by the National Patient Safety Agency (including briefing and debriefing) were undertaken correctly by theatre teams.