Circle Health Group Limited

Sarum Road Hospital

Inspection report

Sarum Road
Winchester
SO22 5HA
Tel: 01962844555

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

Ratings

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

Summary of findings

Overall summary

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

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

However:

- Emergency equipment checks did not always adhere to hospital policy and there were gaps in some equipment cleaning schedules.
- Security to the theatre environment needed to be improved.
- Staff were not always able to identify who had responsibility for tasks in the manager's absence.
- Patient risk assessments were not always completed and follow up actions were not always recorded. Also, staff did not always document details of incidents and share learning on their incident forms.
- Staff in the outpatient and diagnostic imaging services felt under pressure due to staffing levels and felt the communication around this was lacking.
- The diagnostic imaging service did not check mobility requirements for NHS patients at booking stage for the mobile magnetic resonance imaging (MRI) machine.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

However:

- Staff in the outpatient and diagnostic imaging services felt under pressure due to staffing levels.
- The service did not ensure all consumables were in date.
- The service did not always document details of incidents and shared learning on their incident forms.
- The service did not check mobility requirements for NHS patients at booking stage for the mobile magnetic resonance imaging (MRI) machine.

Diagnostic imaging was part of the 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, responsive, and well-led.

Medical care (Including older people's care)

Good 

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

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

Summary of findings

- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were generally clear about their roles and accountabilities but when leaders were absent, there was a lack of clarity about roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Three sharps bins were overfilled and included items that were not sharps.
- Staff were not able to identify who had responsibility for some tasks in the manager's absence.
- There was no evidence reflecting when an observation trolley and scalp cooler had last been cleaned.
- All parts of risk assessments were not always completed and follow up actions were not always recorded.

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

Outpatients

Good

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

- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

Summary of findings

- Staff provided good care and treatment, gave patients enough to eat and drink and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
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However:

- Staff in the outpatient and diagnostic imaging services felt under pressure due to staffing levels.

Outpatients was part of the 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, responsive, and well led.

Surgery

Good

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

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

Summary of findings

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

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However:

- Checks of emergency equipment did not always adhere to hospital policy.
- Security to the theatre environment needed to be improved.

Summary of findings

Contents

Summary of this inspection

Background to Sarum Road Hospital

Sarum Road Hospital is operated by Circle Health Group. BMI Healthcare became part of the Circle Health Group in December 2019.

Sarum Road Hospital is a private hospital in Winchester, Hampshire and provides a range of medical, surgical and diagnostic services to patients who pay for themselves, are insured, or for some specific surgical procedures, are funded by the NHS.

The hospital has 48 registered beds. Facilities include two operating theatres, a two-bed close observation unit, and X-ray, outpatient and diagnostic facilities. There are no emergency facilities at this hospital.

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

Surgeons, anaesthetists and physicians worked at the hospital under practising privileges.

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

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

The hospital has a registered manager who has been in post since March 2020.

We inspected the hospital in February 2016 where we rated the hospital good overall. We inspected the medical care service in August 2018 to follow up some specific concerns and rated the service good overall.

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

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

How we carried out this inspection

During the inspection, we assessed the surgical, oncology and outpatients and diagnostics imaging services. We reviewed the overall governance processes for the hospital and report on this as part of the well-led domain. We spoke with 42 members of staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, facilities staff and senior managers. We spoke with 13 patients and observed patient care and procedures with the consent of the patients.

We looked at patient waiting areas and clinical environments, attended staff huddles, looked at 19 patients' care and treatment records, and at hospital policies, procedures and other documents relating to the running of services.

Summary of this inspection

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

Areas for improvement

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

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

Action the service SHOULD take to improve:

- The provider should ensure that staff adhere to hospital policy regarding the checking of emergency equipment. Regulation 12(2)
- The provider should ensure that staff adhere to hospital policy regarding the safe storage of controlled drugs. Regulation 12(2)
- The provider should ensure that staff adhere to the guidance on safe disposal and appropriate use of sharps bins. Regulation 15(1)
- The provider should ensure staff adhere to equipment cleaning schedules and record cleaning. Regulation 15(1)
- The provider should ensure completion of risk assessments and any findings from risk assessments are actioned and recorded. Regulation 12(2)
- The provider should ensure the roles and responsibilities of staff in the absence of leaders. Regulation 17
- The provider should ensure regular proactive engagement with staff in order to establish a culture where staff feel listened to. Regulation 17(2)
- The provider should ensure that all consumables are in date at all times. Regulation 12
- The provider should consider improving security access to the theatre environment.
- The provider should consider its communication strategy around staffing challenges.
- The provider should consider how staff are able to access relevant internal policies.
- The provider should consider performing regular checks at point of booking regarding mobility needs for patients undertaking magnetic resonance imaging (MRI) scans.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Diagnostic imaging

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

Are Diagnostic imaging safe?

Good

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

Mandatory training

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

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory and statutory training was provided by a combination of eLearning and face-to-face training sessions. Mandatory training was split into departments and job roles. Staff in the diagnostic imaging department had personalised lists of mandatory training, including adult advanced life support, adult basic life support, adult intermediate life support, anti-bribery, aseptic non-touch technique, care and communication of the deteriorating patient, conflict resolution, consent, control of substances hazardous to health, dementia awareness, display screen equipment, documentation and legal aspects, equality & diversity, fire safety in a hospital environment, infection prevention and control, information governance, medical gases, patient moving and handling, prevent, safeguarding children level 2, and safeguarding vulnerable adults levels 2 and 3.

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

At the time of our inspection, 97.8% of staff had completed their mandatory training against a organisational target of 90%. Staff who were non-compliant were booked in to complete it in January 2022. Staff also completed targeted training, such as IR(ME)R (Ionising Radiation (Medical Exposure) regulations) training, mammography, radiation protection, and management & leaderships courses.

Safeguarding

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

Good

Diagnostic imaging

Staff received training specific for their role on how to recognise and report abuse. Safeguarding children and vulnerable adults formed part of the mandatory training programme. Staff we spoke with told us they had received safeguarding training. All clinical staff completed level 3 training for adults safeguarding. Staff also received level 2 training in children's safeguarding. This was in line with the recommendations from the Intercollegiate Document adult safeguarding: roles and competencies for health care staff (August 2018) and the Intercollegiate Document safeguarding children and young people: roles and competencies for healthcare staff (January 2019).

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

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

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

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

Cleanliness, infection control and hygiene

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

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Examination couches, chairs and pillows had wipeable covers and we saw disinfectant cleaning wipes being used to clean after every patient.

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

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

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

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

Good

Diagnostic imaging

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

Environment and equipment

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

The design of the environment followed national guidance. The design of the environment followed national guidance. The layout of the unit was compatible with health building notification (HBN06) guidance, which lays out the building requirements for hospitals.

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

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

The service had recently started using a mobile MRI unit, a self-contained suite that housed the scanner, control room, and a patient changing room. It's called a mobile unit because the suite is built in a semi-trailer which can be transported between multiple locations or connected directly to a facility. In accordance with MHRA guidance, the MRI room was equipped with oxygen monitors to ensure that any gas leaking, for example liquid nitrogen or liquid helium would be identified. This ensured that oxygen levels remained safe not compromising patient safety.

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

Unauthorised access was restricted. We saw warning signs and lights in use on the day of our inspection, all areas were monitored and had oversight from staff. All relevant equipment in the MRI unit was labelled in accordance with MHRA recommendations. For example, “MR Safe” or “MR Unsafe” to indicate that these pieces of equipment were safe or unsafe to use in an MR environment as per the MHRA safety guidelines for magnetic resonance imaging equipment.

There were two x-ray rooms, and a mammography room, accessed off the main reception. The rooms where radiation exposure took place were clearly marked with warning signs and lights. There was also an ultrasound room, where consumables were stored. We found several consumables were out of date. We raised this with the service, and they removed them on the day.

Lead screens were in place to protect staff from radiation. These were checked annually by the service’s medical physics expert. Lead aprons were available for use if required and were subject to regular integrity checks by the service’s medical physics expert.

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

Good

Diagnostic imaging

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

Servicing and maintenance of premises and equipment was carried out using a planned preventative maintenance programme. During our inspection we checked the service dates for equipment, including scanners. All the equipment we checked was within the service date. The generators were also tested monthly on a planned schedule to ensure patient scanning was not affected.

Resuscitation equipment was available in the hallway. This was shared with the outpatients department. The resuscitation equipment was visibly clean, serviced and tagged to indicate whether equipment had been tampered with.

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

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

Assessing and responding to patient risk

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

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

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

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

Staff responded promptly to any sudden deterioration in a patient's health. The policy for management and transfer of deteriorating patients was detailed and in line with national guidance. There was a clear escalation process for managing deteriorating patients. Whenever the patients required a higher level of care which was not available on site, staff told us they would call 999 for an emergency transfer to the local hospital. The service had an agreement with the local hospital to ensure the transfers.

All staff completed adult basic life support (BLS) training. At the time of our inspection 97.8% of staff were compliant with adult BLS training.

Good

Diagnostic imaging

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

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

Clear signage was in place to warn patients of areas where radiation exposure took place, therefore limiting risk of accidental exposure. Each imaging area contained an emergency alarm cord in the event of emergency or patient collapse.

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

Staffing

The service generally 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 generally reviewed and adjusted staffing levels. Managers adjusted the skill mix, and gave bank, agency and locum staff a full induction.

The service generally had enough staff to keep patients safe. There were five radiographers in total, two of whom were MRI radiographers. Of the three radiographers working within the department, two were part time, and only one working full time. Staff told us they felt under a lot of pressure. Staff also told us this had been raised with senior management, but response times and engagement had not been ideal.

The manager was generally able adjust staffing levels daily according to the needs of patients. However, the service had a high vacancy rate. Staff told us they had made senior leaders aware of the under staffing, but no action had followed. At the time of our inspection there were three vacancies, two for bank radiographers, and one vacancy for a senior radiographer.

The service had reported some sickness for clinical staff in the past six months. This created additional pressure in order to be able to cover shifts in the absence of some staff members.

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

Medical staffing

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

The service had enough medical staff to keep patients safe. There was a resident medical officer (RMO), with the relevant experience on site 24 hours, seven days a week with on-call access to patients' consultants during evening and

weekends. The RMO told us the consultants were easy to contact, responsive to requests and they felt valued by consultants asking their opinion too. The RMO was trained in advanced life support and held a bleep for immediate response, for example, in the case of cardiac arrest. Nursing staff told us the RMOs were approachable and responsive when required.

Records

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

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

Records were mostly stored securely. Patients' personal data and information were kept secure. Only authorised staff had access to patients' personal information. Staff training on information governance was part of the mandatory training. However, we noticed three patient sheets left in the reception area, containing confidential information, and not secured. We raised this with the service on the day and they moved the files to secure storage.

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

We reviewed four patient records during our inspection and saw records were accurate, complete, legible and up to date. The service provided electronic access to diagnostic results and could share information electronically if referring a patient to a hospital.

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

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

Medicines

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

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

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

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Staff labelled contrast media in line with the manufacturers' guidelines and disposed of contrast media which had not been used according to the manufacturer's guidelines.

Good

Diagnostic imaging

Incidents

The service did not always manage patient safety incidents well. Staff did recognise incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

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

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

There were no never events reported for the service in the last 12 months. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

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

Staff used a specific form to record and report radiation doses greater than the intended dose. The service had a named radiation protection advisor (RPA) who would review any incidents relating to radiation. There had been two radiation incidents in the 12 months prior to our inspection.

These incidents were subcategorised as unintended exposure due to wrong body part being scanned. We reviewed both incidents and found them to be lacking in detail and clarity. The outcome, patient and staff involvement and the process of the investigation were not specified in the incident forms. The forms also did not include any learning or mitigation actions. However, staff had access to learning from incidents from other provider sites and we saw posters with learning from incidents in the department.

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

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us that learning from incidents was shared at daily safety huddles, team meetings, and by email.

Are Diagnostic imaging effective?

Inspected but not rated

We did not rate effective during our previous inspection. We do not rate effective in diagnostic imaging, according to our current methodology.

Good

Diagnostic imaging

Evidence-based care and treatment

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

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

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

Patients care and treatment was delivered, and clinical outcomes monitored in accordance with guidance from NICE. NICE guidance was followed for diagnostic imaging pathways as part of specific clinical conditions.

The service had local rules based on national guidelines. We found the local rules provided clear guidance on areas relating to hazards and safety and the responsibilities of staff to ensure work was carried out in accordance with the local rules. The MRI and X-ray unit had its own local rules with a suitable review date. All local rules were all in date.

Local audits were completed monthly, quarterly and annually to assess clinical practice in accordance with local and national guidance. Areas audited were infection and prevention control, patient experience, waiting times, image quality assurance, IR(ME)R (Ionising Radiation (Medical Exposure) regulations) procedures and quality of referral form.

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

Nutrition and hydration

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

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

Pain relief

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

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

Good

Diagnostic imaging

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

Patient outcomes

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

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

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

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff skills were assessed as part of the recruitment process, at induction, through the probation period and then ongoing as part of the continuous professional development (CPD) process.

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

Managers supported staff to develop through yearly, constructive appraisals of their work. Data provided by the service showed that 85% of staff had completed an appraisal in the last 12 months prior to the inspection. This was in line with the internal target.

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

Good

Diagnostic imaging

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

Multidisciplinary working

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

Staff told us that they worked closely with other providers who referred patients to their service to provide a seamless treatment pathway for patients. Staff told us they collaborated well with other departments, and that they attended monthly meetings to share learning.

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

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

Seven-day services

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

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

Health promotion

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

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

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

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.

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

Good

Diagnostic imaging

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

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

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

Are Diagnostic imaging caring?

Good

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

Compassionate care

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

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

Patients said staff treated them well and with kindness. Patients we spoke with described staff as caring and kind. We also reviewed 11 thank you cards, reflecting very positive feedback from patients from the past 12 months.

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

Patient feedback was captured through the friends and family test (FFT) survey. Details on how to give feedback was displayed on notice boards throughout the clinic. Managers told us that patient feedback was reviewed monthly and shared with at staff meetings. Any dissatisfied patients, if they left their contact details, would be contacted and resolve the issues raised. We reviewed patient feedback from the last 12 months, and noted 97.3% of this was positive, where patients responded that they had a very good or good experience of the service. Staff told us negative comments were scrutinised for opportunities to drive improvement in the service which included changes to premises, staff training or patient information.

Emotional support

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

Good

Diagnostic imaging

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

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

We observed staff provide ongoing reassurance throughout the MRI scan, they updated the patient on how long they had been in the scanner and how long was left.

Understanding and involvement of patients and those close to them

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

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

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

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

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

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

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

Patients gave positive feedback about the service. Friends and family test (FFT) results for 2021 showed 97.3% of patients responded that they had a very good or good experience of the service.

Are Diagnostic imaging responsive?

Good

We previously inspected diagnostic imaging alongside outpatients. Our rating of responsive stayed the same. 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.

Managers planned and organised services so they met the changing needs of the local population. The service provided flexible appointments to accommodate the needs of patients who were unable to attend on certain days or at certain times.

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

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

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

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

Meeting people's individual needs

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

The service and most areas within the service were accessible to wheelchair users. This included level access from the car park set down area and automatic entry doors at the main entry as well as entrances to the diagnostic imaging department. Wheelchair users who could mobilise for short periods without a wheelchair had support from staff to walk the short distance from the last Magnetic resonance imaging (MRI) safe wheelchair access point to the scanner. However, the unit was not suitable for all patients with mobility issues and the service did not perform checks at point of booking. On the day of the inspection, we saw a patient in a wheelchair not receiving a scan due to this. We made the Provider aware of this on the day of the inspection and they told us they would ensure patient mobility is clarified when booking MRI scans, and that the corporate team would explore further improvements.

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

Patients also had a panic button they could press any time during the scan to summon help. Staff could stop the scanning immediately if the patient requested this.

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

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

There was a poster detailing costs for self-pay. This meant a lower risk of cancellations or complaints relating to costs of procedures.

Good

Diagnostic imaging

An interpreting service was available for patients whose first language was not English. All staff we spoke to showed good knowledge and awareness of the service and knew who to contact if required. Further, patients and carers were able to access translations into 56 languages of diagnostic imaging procedures through a link displayed in the waiting room.

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

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

Access and flow

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

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

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

Managers worked to keep the number of cancelled appointments to a minimum. The service did not have any cancellations in the last six months.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. All the patients we spoke with knew how to make a complaint or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

The service reported they had received five complaints in the last 12 months. The complaints were investigated and responded to in line with the policy. We saw evidence of the changes implemented as a result of the complaint whereby the imaging referral form was updated to make it clear to patients the type of diagnostic tests being requested and the potential charges.

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

Good

Diagnostic imaging

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us that learning from complaints was communicated to them through meetings and emails.

Are Diagnostic imaging well-led?

Good

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

Leadership

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

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

The hospital was led by a senior management team consisting of an off-site supervisory executive director, an on-site registered manager and a director of clinical services.

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

For our detailed findings on leadership please see the Well led section in the surgery report.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

We reviewed the department's vision and strategy document, mainly focused on improving clinical safety, improving clinical effectiveness, developing leadership and culture, ensuring robust clinical and consultant governance, and developing the services. The service planned to establish a static MRI scanner in order to drive the business forward. The clinical strategy for the department also included compliance with meetings attendance, clinical mentorship and competencies and active engagement in meetings.

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

Culture

Staff felt generally 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.

Good

Diagnostic imaging

Staff were mostly positive when describing the culture within the service. They generally felt supported by leaders and colleagues within the service. However, they told us they did not get responses to what they were escalating. Most staff we spoke with were happy in their role and stated the service was a good place to work.

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

However, staff reported not feeling listened to in terms of staffing pressures. Staff told us they had told senior leaders about the daily challenges due to understaffing, but no engagement had followed. Further, staff told us senior leaders were generally approachable, but not visible, as they did not visit the department regularly.

The service promoted equality and diversity and it was part of mandatory training. Managers and staff promoted inclusive and non-discriminatory practices.

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

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

However, staff did not always feel supported or listened to with regards to their views and opinions, particularly regarding workloads and understaffing.

We raised this with the Provider who confirmed their commitment to improving communication on recruitment and wider initiatives around staffing.

Governance

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

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

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

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

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

For our detailed findings on governance please see the Well led section in the surgery report.

Good

Diagnostic imaging

Management of risk, issues and performance

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

Performance was monitored at local and corporate level.

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

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

Staff we spoke with were aware of the risk recording tool available. They were able to give us examples of using it to highlight risks. Staff we spoke with were aware of the diagnostic imaging risk register which formed part of the general location risk register.

Information Management

The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

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

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

For our detailed findings on information management please see the Well led section in the surgery report.

Engagement

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

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

We reviewed the equality, diversity and human rights policy, demonstrating that leaders were committed to driving equality.

Good

Diagnostic imaging

Leaders engaged with staff using a variety of methods, including; annual staff surveys, team meetings, electronic communication, newsletters, staff notice boards and informal discussions.

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

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

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

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

The diagnostic imaging department offered apprenticeships and training opportunities which helped to develop the skills and offered career progression to individuals in the team.

For our detailed findings on Learning, continuous improvement and innovation please see the Well led section in the surgery report.

Good

Medical care (Including older people's care)

Safe	Good
Effective	Requires Improvement
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. Mandatory training in the oncology service consisted of 26 courses. The target compliance rate set by the service was 100%, although the provider target was 90%. Hospital data showed current compliance rate was 95.9%. The courses not achieving 100% compliance were, Care and Communication of the Deteriorating Patient which one member of staff needed to complete, Fire Safety in a Hospital Environment Workshop which two members of staff needed to complete, Patient Moving and Handling and Patient Moving and Handling Workshop which both required one member of staff to complete.

The Systemic Anti-Cancer Therapy Competency (SACT) passport was in use by the Specialist Oncology Nurses in the unit. This passport was developed by United Kingdom Oncology Nursing Society (UKONS) to ensure SACT training is consistent, up to date and includes standardised knowledge and best practice across services. Staff had achieved their SACT competencies target of 100%

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Benchmarking data, against England acute hospitals averages for Dementia and Disability, showed the hospital performed less well, with dementia at 78.5% (England average 80.5%) and disability 79.9% (England average 82.1%)However, the demographic of hospital patients did not always allow staff to implement their training fully, but they had good awareness of those with different needs.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training was online and staff said it was easy to check and highlighted when training was required. Staff also had scenario based training, face to face training and hospital wide study days. Any training outside of the mandatory framework could be requested if it was demonstrated to benefit patients and the hospital.

Good

Medical care (Including older people's care)

Safeguarding

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

Nursing staff received training specific for their role on how to recognise and report abuse. Overall hospital compliance with safeguarding training, which was at level 1, 2 and 3 depending on staff role, was 100% for both adults and children. The hospital target was 100%. Staff were able to explain different types of abuse. Staff explained how they would respond if they witnessed or suspected abuse and told us they would report it to the clinical services manager and the safeguarding lead.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff gave good examples of how they dealt with a disclosure of abuse and sought additional advice and guidance from their safeguarding team to ensure good practice for their patient. Staff advised they could move patients to separate rooms to enable privacy, dignity and safety of their patients.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was a designated safeguarding lead at the hospital and most staff knew who the safeguarding lead was and how to escalate any concerns. One member of staff wasn't sure who the safeguarding lead was.

Staff followed safe procedures for children visiting the ward. Staff have had training in Children's Safeguarding level one. The service did not treat children and had not allowed visitors during the COVID-19 pandemic but instead provided staff chaperones if patients requested them. Staff reported it was rare to have any children visiting, but they had previously encouraged this, before the COVID-19 pandemic, to show children the ward, so they knew it wasn't scary for their parents. We felt assured that staff had the correct training to identify any issues in relation to visiting children, should that happen.

Cleanliness, infection control and hygiene

The service generally 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 oncology suite, Mulberry Unit, was visibly clean. Staff used control measures to prevent the spread of infection in line with guidance. Due to the COVID-19 pandemic, Oncology patients had a separate entrance to the unit, to safeguard against infection and reduce contact with other members of the public.

The service had suitable premises and equipment to meet the needs of patients. The oncology suite consisted of a reception area, five patient treatment rooms, consulting room, a quiet room and a clinical room on the ground floor. All patient areas were visibly clean and tidy. Hand sanitisers were situated around the unit and were full. Wall mounted personal protective equipment (PPE) dispensing stations were complete with aprons and three different glove sizes. There was a table set up inside the department patient entrance, with hand sanitiser, a temperature check and box of masks. However, the box of masks was empty.

All patients requiring treatment had a COVID-19 PCR (polymerase chain reaction) test. Anyone with a positive result did not commence treatment. Patients could arrange their own PCR tests or the hospital could carry out the tests for them. These were done outside to prevent infection entering the service. The hospital policy required loved ones to show evidence of a negative LFD (lateral flow device) test before entering the area. However, a family member stated they had not been asked to show any evidence of an LFD result on the day of their visit.

Staff were tested twice weekly and results were entered onto the hospital database. The vaccination status of all staff was noted in their personnel records.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Treatment rooms were clean and tidy. Chairs were clean and had easy to clean coverings and appeared well maintained. Some rooms had beds and these appeared well maintained and were clean. Flooring in all rooms was a wooden laminate type which meant it was easy to clean. The scalp cooler appeared clean, however the cleaning sticker on it was dated 29 November 2021. This machine was mobile and transferred to different rooms to treat different patients, therefore we could not be assured it was regularly cleaned and may pose a risk of infection to people.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Each room had a checklist for cleaning. Checklists were completed for the day of inspection. Staff said housekeeping liaised with ward staff to identify which rooms may need to be a priority to clean.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw staff following 'bare below the elbow' guidance, wearing masks and washing their hands before and after patient care. We saw one nurse identify that they had a hole in their glove when about to treat a patient. The nurse left the room to dispose of the damaged glove and returned with new gloves.

Staff cleaned equipment after patient contact and mostly labelled equipment to show when it was last cleaned. We saw "I am clean" stickers on most equipment, but one observation trolley did not have any cleaning sticker on, so staff could not be assured when this was last cleaned. This meant we were not assured this item of equipment was safe to use. Other items of equipment had "I am clean" stickers dated for 6 January 2022.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff did not always manage clinical waste well.

The oncology unit was awarded the Macmillan Quality Environment Award. The award is assessed on the following criteria, a successful MQEM environment is: welcoming and accessible to all, respectful of people's privacy and dignity, supportive of the users' comfort and well-being, gives choice and control to people using your service and listens to the voice of the user.

Clear fire exit signs were present throughout the service area. We saw two fire extinguishers on the unit. They were in date and fixed securely to the wall.

We saw one broken window in the unit and brought this to the attention of staff. Staff said this has been raised and documented on the hospital maintenance log and was waiting to be fixed.

Patients could reach call bells and staff responded quickly when called. All patient treatment rooms had call bells. Staff ensured that call bells were in reach and advised patients where the call bell was located.

Staff carried out daily safety checks of specialist equipment. The emergency trolley was checked both daily and weekly. Equipment on the top of the trolley such as the defibrillator machine were checked daily, and the trolley contents were checked weekly. The trolley was sealed with a tamper proof seal which was intact and corresponded to the number in the trolley checklist. We broke the seal to inspect the trolley contents. The defibrillator machine had a clear in date service sticker and next service due date clearly written on it. The contents of the trolley all correlated to the checklist. One item,

a mask, had split packaging. This was brought to the attention of staff, and they immediately removed the item. All the items in the correlating drawers were present and in date where applicable. Expiry due dates were clearly documented. The trolley checklist was detailed, comprehensive and easy to follow in the event of an emergency. It had up to date guidance on resuscitation and used pictorial guides to assist use.

However, the observation trolley also did not have a PAT (Portable Appliance Test) testing sticker or service sticker on it.

The service had enough suitable equipment to help them to safely care for patients. Patients in the oncology unit have access to a scalp cooler, and all staff were trained to use this equipment. Scalp cooling can reduce hair loss caused by chemotherapy. The service sticker on the scalp cooler was dated 2 February 2021 but did not have a next due date on it. We saw two drip monitors had cleaning stickers dated 6 January 2022 but both had in date service stickers.

Heat pads were also available for patients, these can help with pain. We checked five heat pads and one was found to have an expired PAT testing service date on the control unit, so was removed by staff. Staff reported they had enough equipment to meet their patients' needs.

Staff did not always dispose of clinical waste safely. We saw three sharps bins in the clinical room that contained other items besides sharps, such as wipes. All three sharps bins were overfilled. This was brought to the attention of staff, but they could not explain why the bins contained other inappropriate items but would look into the issue. We saw purple lidded cytotoxic waste bins used appropriately and not overfilled and these were collected on a regular basis.

Assessing and responding to patient risk

Staff did not always complete and update all parts of risk assessments for each patient. Staff did not always identify or quickly act upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients but did not always escalated them appropriately. The Oncology Unit, Mulberry Unit, provided treatment for day patients only. Patients were seen by consultants and a nurse at their first appointment. Nurses then carry out a consultation including bloods, vein assessments and explain the possible treatments for the patient. Any abnormalities were noted by the nurse and communicated to the consultant electronically. The assessment results were documented electronically. One patient record did not have any documented actions or discussions with the patient following an issue highlighted from the risk assessment

The Oncology unit use the UKON triage tool (United Kingdom Oncology Nursing Society) to detect deteriorating patients. Oncology nursing staff use this triage tool to help identify the urgency of a problem such as neutropenic sepsis. Neutropenic sepsis is a life-threatening complication of anticancer treatment. The unit has a sepsis box in place with equipment needed to treat a patient with suspected sepsis all in one place. This meant staff could give the urgent lifesaving treatment to a patient with suspected sepsis without delay. We saw good documentation of clear advice given regarding emergency admission if a patient's temperature was more than 37.5 degrees.

Staff told us they would call the consultant to discuss any deteriorating patient, ask them to prescribe any necessary medicine. Consultants would then review the patient the following day.

The hospital had a transfer agreement with a nearby NHS trust and a policy for patients who become unwell. If the consultant was not present during a chemotherapy treatment, staff telephoned the consultant for advice. If immediate help was needed to stabilise the patient, staff contact the resident medical officer who was on site 24 hours a day.

Good

Medical care (Including older people's care)

Staff told us they had regular blood test collections, three a day, and they could arrange taxi collections outside of the normal collections if required.

Staff did not always fully complete risk assessments for each patient on admission or arrival. They did use a recognised tool, but did not always review this regularly, including after any incident. The hospital used a combined risk assessment tool which included falls, manual handling, pressure ulcer risk, MUST (Malnutrition Universal Screening Tool), bed rails and visual infusion phlebitis. We saw four sets of patients notes. In one set the patient's VTE (Venous Thromboembolism), falls risk and normal bowel movements had not been recorded. VTE is the risks of a blood clots.

In one set of notes, the MUST score had not been recorded. One patient record had recorded a rising pressure risk score, but there was no documented action taken by staff. Staff knew about but did not always deal with any specific risk issues.

In two patient records, staff used a nationally recognised assessment tool to document skin pressure risk, (The nationally recognised tool score gives an estimated risk for the development of a pressure sore in each patient). In one record the score was high, indicating that patients' risk of developing pressure ulcers were increased and in another patient record, staff had recorded a rising pressure risk score, but there was no documented action taken by staff, for instance, alerting this issue to the patient or their GP or following it up. We discussed this with a staff member who agreed that no action had been taken or documented.

We asked staff about the observation and management of extravasation, as we could not see any observations documented (extravasation occurs when a drug leaks out of the vein and into the surrounding tissue. This can cause tissue damage, blistering and ulceration). Staff said observation was visual and frequent, but those observations were not written in patient notes. Staff said if extravasation were to occur, they have a process to follow and that would be written in patient notes. Staff said there had been one incident of extravasation in the past year. We saw the record of this in the patient's notes and the management and treatment of it was well documented.

We saw a sealed cytotoxic extravasation box with an expiry date of 31 August 2022 and a sealed anaphylaxis kit in the clinical room. UKON guidelines for the management of extravasation were present, along with guidance for the management of neutropenic sepsis. Patient notes documented clear advice given for neutropenic risk and emergency admission to an NHS acute hospital if temperature is more than 37.5 degrees.

Staff were not aware of the administrative processes regarding discharge. We saw a stack of patient discharge letters dating from the three month period leading up to the inspection. We highlighted this to staff who were unsure if they were letters which had not been sent to GPs, or copies for patient records. Staff addressed this issue the following day and senior leaders subsequently confirmed the letters were copies waiting to be filed, but that the originals had been sent to GPs within agreed timescales. Shift changes and handovers included all necessary key information to keep patients safe. Nursing staff have recently introduced a communications book to identify any patient related tasks that are outstanding and need following up or completion. These could be scan or test results that may be needed before treatments can start.

For out of hours service, staff recorded details of concerns or issues and enter these into patient records on their return to work or sent them electronically if they were not due to work the following day.

Nurse staffing

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

Good

Medical care (Including older people's care)

The service had four specialist oncology nurses, one health care assistant and four consultants who attended on specific weekdays for clinics. The health care assistant sometimes supports staff on the surgical ward. The service could flex up or down its staffing needs depending on the number of patients and their treatment needs. If required, the service used bank staff who were familiar with the oncology unit. The service rarely used agency staff and if they did, those staff had worked in the unit previously and were familiar with it. New and unfamiliar staff have an induction as part of their training. For overall bank and agency rates, please see the surgery report.

The service had enough nursing and support staff to keep patients safe. Staff had a rota system to schedule staff working days. The staff in the unit were all part time and said staffing can be easily adjusted up or down daily by the service lead to meet the needs of patients. Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift. The service would sometimes use bank staff but rarely used agency nurses and managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

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 medical staff who provided oncology care, also regularly worked within the NHS. Medical staff worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital.

A resident medical officer (RMO) provided 24-hour, seven day a week cover at the hospital on a two week on, two week off working pattern. The RMO cover was supplied though an agency who also checked their training, credentials and competency. This included ensuring the RMO was trained in advanced life support. The RMO reported they did not attend the Oncology unit often as the staff there were very capable. The RMO felt they had enough breaks throughout their day and were not disturbed often during the night.

The service always had a consultant on call during evenings and weekends. Staff reported they could always reach a consultant for advice at any time, but they rarely needed to contact them. Staff said they have not had any trouble contacting consultants, even if they were on leave, they were happy to support staff.

Records

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

Patient notes were generally comprehensive and all staff could access them easily. Records were stored securely. Patient records were kept both electronically and on paper. Staff reported the service were planning to use an entirely electronic system in the future, but they did not know when. Having both paper and electronic records can create the possibility of staff not having complete patient information. The paper records were stored in lockable filing cabinets behind a key coded door in the reception area. We saw staff ensuring the door was locked on exit but filing cabinets were not always locked when reception area was unattended

Hospital data showed their cancer documentation audit, based on medical notes for 2021 scored 92.4%. Their system used a red, amber, green (RAG) status, and cancer documentation was rated amber which their system determined as, required actions to be implemented. The hospital data showed this was an ongoing process to implement.

Good

Medical care (Including older people's care)

Medicines

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

Patients attending the oncology day unit received intravenous chemotherapy. Staff followed safe systems and processes when they administered chemotherapy.

The service did not have a Specialist Oncology Pharmacist in post at the time of inspection. There was a Senior Pharmacy Technician supporting the oncology unit with the dispensing of chemotherapy medicines. The senior pharmacy technician had to undertake a longer process to ensure medicines were prescribed and dispensed safely by enlisting the help of specialist oncology pharmacists from other hospitals in the Circle Health group to screen prescriptions and drug charts remotely. This process, whilst ensuring patient safety was maintained, delayed some patients' receiving their chemotherapy. Staff told us delays had been between 10 and 60 minutes.

We saw that medicines were well organised and stored safely. The controlled drugs storage cabinet was securely bolted to a wall and intravenous fluids were stored safely off the floor.

Staff followed systems and processes to prescribe and administer medicines safely. The dispensing process was managed well with the pharmacist cross checking with nursing staff and the resident medical officer if required, on both the electronic prescribing system and paper charts as well. Staff said there were monthly medicine reconciliation audits where 15 charts were inspected.

Staff completed medicines records accurately and kept them up-to-date.

Staff stored and managed all medicines well. The controlled drugs storage cabinet was securely bolted to a wall and intravenous fluids were stored safely off the floor. Nursing staff stored medicines securely and within their recommended temperature ranges. Dedicated cupboards and fridges were used to store chemotherapy. We saw that the checking by oncology staff of minimum and maximum temperatures took place and was recorded. Medicines were available in oncology to give immediate treatment for any adverse reactions to medicines.

Staff learned from safety alerts and incidents to improve practice. Staff said that learning from any incidents was shared across the whole hospital and gave an example of a dispensing error being identified and corrected. Learning was shared through governance meetings and at daily communication meeting, both for the oncology team and whole hospital team leads.

Incidents

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

All staff knew what incidents to report and how to report them. Staff knew who to escalate incidents to and raised concerns and reported incidents and near misses in line with provider policy. The hospital had a central process to cascade National Patient Safety alerts to all staff and they discuss any alerts in the medical advisory committee meetings to determine what actions were required.

The service had reported no never events between 1 July 2020 and 30 June 2021.

Good

Medical care (Including older people's care)

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff understood duty of candour, a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff were aware of their responsibility to inform patients when anything went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. This was shared via emails, staff meetings and morning feedback calls. Staff told us of a recent incident in another hospital within the BMI group, and this was emailed to all staff to share learning. Staff told us they received information highlighting any current issues such as falls awareness information and met to discuss the feedback and look at improvements to patient care.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations and gave an example of a patient being able to meet with a consultant to discuss their complaint. Managers debriefed and supported staff after any serious incident and staff also supported each other at their weekly meetings.

We received one expected death notification from the hospital about an oncology patient. The notification was sent because the patient had received chemotherapy within 30 days of their death. There were no unexpected deaths within the service or hospital.

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

Requires Improvement

We did not rate effective in our last inspection. We have now rated it as requires improvement.

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 but were not able to access internal policies directly and needed their manager to provide access. We saw guidance for the management of neutropenic sepsis and use of the UKONS triage tool and evidence that staff followed these guidelines. However, staff could not easily navigate the IT system to find policies when the manager was not present.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients attending the oncology service were day patients and staff gave patients enough food and drink to meet their needs and improve their health.

Staff also gave nutritional information to patients as part of their care planning. Staff used guidance from the British Society of Integrative Oncology in relation to their dietary needs.

Good

Medical care (Including older people's care)

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff used the malnutrition universal screening (MUST) tool. MUST is a screening tool to identify adults who may be at risk of malnutrition, under nourished or obese. We looked at four patient records and saw one patient record where their MUST score had not been recorded.

Specialist support from staff such as occupational therapists was available for patients who needed it. Staff said they could refer any patients requiring specialist advice and have used the Occupational Therapy service to assist patients with any mobility or pressure ulcer relieving needs.

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.

Although staff did not assess patients' pain using a recognised tool, pain relief was given in line with individual needs and best practice. They used verbal assessment's during patient consultations, using questions on type of pain, place of pain, did anything make the pain worse. We saw that patients had an individual pain management plan. Other resources to manage pain such as heat pads were available for patients.

Staff prescribed, administered and recorded pain relief accurately. We saw four patient records and pain management was well documented in them all.

Patient outcomes

Staff did not monitor the effectiveness of care and treatment.

The hospital did not measure or benchmark the effectiveness or outcomes of the cancer care they provided. The service measured certain elements of the care provided, but patient outcomes could not be reviewed, compared and used for improvement or benchmarked against other Circle Group locations or external organisations. However, Circle Group was reviewing involvement in national audits at an organisational level.

The areas the service monitored and benchmarked against were, UKONS triage, cancer services documentation, IPC compliance, medicines management and MDT compliance. However, the service was developing a cancer dashboard to enable internal benchmarking and comparisons to national services delivering cancer care.

The service contributed to the Private Healthcare Information Network (PHIN). Data was submitted in accordance with legal requirements which were regulated by the Competition Markets Authority (CMA). PHIN data showed 385 patients had used the service from 1 July 2020 to 30 June 2021.

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.

Consultants worked at the hospital under practising privileges. Practising privileges give medical staff the right to work in an independent hospital following approval from the Medical Advisory Committee (MAC).

Good

Medical care (Including older people's care)

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. SACT competencies were used for the specialist oncology nurses. The SACT tool is used to train and assess chemotherapy skills for cancer nurses. Staff appraisals were annual and objectives set quarterly but can be added to outside of these timescales if they arise. Staff appraisals had also met the 100% target.

Managers gave all new staff a full induction tailored to their role before they started work, including agency staff. Staff said they have the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge, such as attending conferences.

Multidisciplinary working

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

There was effective multidisciplinary team (MDT) working in oncology both with in the hospital and externally with GP's. Hospital data from the cancer MDT audit January 2021 to December 2021 showed there was a 100% compliance with MDT working. Oncology staff told us the consultants' patients treated at the hospital were discussed at cancer MDT meetings held at local NHS Trusts.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. There were monthly clinical governance meetings held which were attended by senior leaders and consultants. The hospital had amalgamated their morbidity and mortality review meetings into the monthly clinical governance meetings. Patients had their care pathway reviewed by relevant consultants.

Seven-day services

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

The oncology service was available Monday to Friday. Staff administered chemotherapy treatments throughout the week. Consultants of different specialities attended on one agreed day per week to hold clinics but were available for staff to contact them at other times.

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

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

For patients who were receiving chemotherapy there was seven-day support available through an out of hours contact number to oncology trained staff, if a patient had concerns or any adverse effects.

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. Staff had undertaken training facilitated by the British Society for Integrative Oncology (BSIO) and were planning to create more information for patients on leading healthier lives.

Good

Medical care (Including older people's care)

The BSIO focuses on nutritional, lifestyle and complementary approaches that have sufficient evidence of safety and efficacy to be integrated into care alongside conventional therapies.

The hospital ran 'Looking good feeling better' sessions for patients receiving treatment, to promote their well-being. This included 'make up' advice. The hospital also provides complementary therapies for patients' such as massage and reflexology.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the mental capacity to make decisions about their care. The oncology consultants sought consent from patients, which included a discussion of the risks and benefits, before patients were admitted as a day case for chemotherapy. The consent process was supported with written information about the specific chemotherapy treatment for patients to take away and read. Staff understood the consent to care and best interest process. They told us of action they would take if someone lacked the mental capacity to make a specific decision.

Staff understood how and when to assess whether a patient had the capacity to make decisions and explained that they would refer someone to an expert if there was an indication of an underlying issues that may affect decision making. Staff training in consent was at 100% compliance.

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. We spoke to two patients receiving care and treatment in the unit. Patients felt the staff respected their wishes and provided dignified care. They felt the staff were always positive and created a friendly atmosphere for patients. One patient said they were very responsive to their needs when they requested to be moved to a quieter room and the staff felt like family to them. They said that staff had respected the patients choice not to discuss their own diagnosis with their family. Patients said they were informed about their treatment and felt able to ask any questions or raise concerns about their treatment or care plans with staff. They said staff would always explain any treatments or possible side effects with them and that this made them feel reassured. Patients described the staff as amazing and said they couldn't fault them. The family members we spoke to, felt involved and informed in their loved ones care and treatment and said the staff were all very caring and compassionate. All the patients we spoke to felt safe having care and treatment there and felt they had received very person centred care.

Good

Medical care (Including older people's care)

We saw staff interactions with patients, and these were respectful, friendly and caring. We saw that these interactions made patients feel calm and reassured about their care. We saw posters displayed on the unit from the hospital wide patient satisfaction survey from December 2021 and these contained positive comments.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients and their families described staff as very supportive. Staff would also signpost patients and their families to other support services as well.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff told us there was a Humanistic counsellor available to support patients if they wanted this and the counsellor was accredited to allied insurance companies used by patients. Patients also told us they were aware of the emotional support services available to them either at the unit or through their insurance companies.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff ensured that patients wishes regarding their care and treatment were respected. Patients said staff took the time to explain their treatments and discuss any concerns or issues the patients may have. Family members said they felt supported by staff and felt they could ask anything about the care and treatment of those close to them.

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

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients and those close to them could give feedback in different ways, there was written feedback available in the hospital and online feedback via Google. We saw posters around the hospital that incentivised staff to be a "Google champion" to encourage patients to give feedback about their care and treatment.

Staff supported patients to make informed decisions about their care. Patients told us they could ask staff about their treatment and any concerns they had, would be addressed.

Patients gave positive feedback about the service. Patients told us they felt safe and were well looked after.

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

Good

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

Good

Medical care (Including older people's care)

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

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

During the COVID-19 pandemic, the hospital has supported the local NHS trust with cancer care and provided their oncology unit for the care of NHS patients for a period of time. The service no longer provides this as the demand has reduced.

Facilities and premises were appropriate for the services being delivered. The unit had been awarded the Macmillan Quality Environment Award, demonstrating it met the needs of patients across a specific criteria.

A dedicated quiet room was available to give patients time to absorb information if needed. Following a discussion with patients, a settee rather than chairs had been provided to make the room feel less clinical.

Patient information leaflets were available throughout the unit and hospital.

There was a separate car parking area for oncology patients.

The hospital had an out of hours telephone service for patients to use if they have concerns or issues which gives access to a Specialist Oncology Nurse for advice and support.

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 liaised with other NHS trusts to ensure patient investigations were received in order to start any treatments. Staff would refer patients to other services such as occupational therapists and hospice care. There was ramp access for anyone with mobility needs.

Managers confirmed that hearing loops were available to the service. They told us they were kept in main reception and could be used to help those who used hearing aids to access services. However, some staff were not aware that a hearing loop was available and thought this was due to an infection risk related to COVID-19.

There was a language interpretation system and staff knew how to access it. Staff said they would always try and seek advice and help from management to help meet their patients' needs.

However, clear masks for those who may need to lip read were not available but staff said they had not had any patients requiring this.

Access and flow

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

Good

Medical care (Including older people's care)

Patients would access the oncology unit service via their insurance company or self funding their own treatment. The service did not treat NHS patients. Patients said they did not experience any delays in beginning any proposed treatment following any necessary health investigations. Patients said they were able to access care and treatment easily and quickly. The service had no delays or waiting lists.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke to felt able to make any complaints. The hospital was a member of the Independent Sector Complaints Adjudication Service code of practice, therefore patients could take their concerns to an outside organisation if they did not feel complaints were adequately addressed internally.

The service clearly displayed information about how to raise a concern in patient areas. We saw "Share your feedback on Google" leaflets throughout the unit and the hospital. We saw patient feedback for several different months displayed on noticeboards in the unit.

Managers shared feedback from complaints with staff and learning was used to improve the service. We saw five complaints and saw that information was shared with staff where appropriate and that learning from complaints was shared with staff.

Staff could give examples of how they used patient feedback to improve daily practice. Staff gave an example of the introduction of a communal area for patients to socialise and not feel isolated. They also started a peer support group facilitated by staff to ensure any clinical queries could have evidenced based answers.

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 skills and abilities to run the service but in the absence of a leader, staff were unclear of their roles and responsibilities. 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 Clinical Service Manager (CSM) was on leave the day of our inspection so we were unable to speak with them. Staff from the department and more broadly, reflected that the leader was involved in the day to day running of the service and was visible and approachable.

In the absence of the manager the staff said they all worked together as a team but no one person was in charge. Whilst the staff worked well together, staff were not able to identify who was responsible for tasks and leadership in the manager's absence. They also were not able to access information on the IT system, for instance policies and audit outcomes. They did reflect that they knew who to escalate immediate concerns to in the manager's absence.

Good

Medical care (Including older people's care)

For the overall hospital leadership, please see the main surgery report.

Vision and Strategy

The service had a vision for what it wanted to achieve but it was not clear if they had a strategy to turn it into action.

Staff discussed their vision for the service at team meetings and set five goals for achieving holistic patient care; a collaborative approach with multi-disciplinary team members, using evidenced based care to support patients with emotional, physical, nutritional, cultural and spiritual needs, to support nursing staff working in an emotionally challenging role and to build upon supportive palliative care knowledge and training to support patients. Staff were proud of this work and the vision was posted in the department hallway where all patients and staff could see it.

However, there was no clear strategy to implement the goals.

For the overall hospital vision and strategy, please see the main surgery report.

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.

Staff said they felt valued and told us about the opportunities they had to develop their knowledge and skills. Staff described the atmosphere as 'happy, friendly and open'.

The service was focussed on patients and staff told us they were able to raise any concerns or issues and were encouraging to patients if they felt they needed to raise any concerns. Staff felt that senior leaders were approachable and visible.

For the overall hospital culture, please see the main surgery report.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations.

The department held a monthly oversight meeting, led by the manager, that fed into the hospital's clinical governance meeting. The meeting agenda included hospital update, reports from other meetings, incidents, infection prevention, courses and e-learning and recruitment. However, meeting minutes did not reflect any discussion of learning from audits. The team had recently re-started mortality and morbidity meetings, but only one had occurred at the time of the inspection.

The meeting minutes did not include audits with reference to clinical patient outcomes as the service did not collect this data. The service is developing a cancer dashboard to enable benchmarking and comparisons to national outcomes. The hospital wide clinical governance committee meeting was held monthly and had started incorporating the morbidity and mortality review. The clinical governance meetings covered broad hospital topics including, risks, staffing, compliance, hospital performance and department reviews.

Good

Medical care (Including older people's care)

The service used monitoring results well to improve safety, it collected safety incident information and shared it with staff, patients and visitors. Safety information was monitored at monthly clinical governance meeting held at the hospital, this included venous thromboembolism assessment and patient safety incidents.

There was a hospital wide governance framework supported by various committees which included those held by the medical advisory committee (MAC), heads of department (HOD), senior nurse group, clinical governance, health and safety and a risk committee which had clear lines of reporting.

For the overall hospital governance please see surgery report.

Management of risk, issues and performance

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

The hospital had identified their top five risks and these were displayed around the hospital. The oncology service had identified a specific risk of the need to manually document blood test results into an electronic prescribing system, creating potential for errors and had identified a resolution to the risk. Risks were discussed and reviewed at monthly meetings Some clinical audits were used to monitor quality and assure risks were managed in relation to prevention and control of infection, such as the management of central venous catheter ongoing care and hand hygiene. For the overall hospital management of risk please see surgery report.

Information Management

The service collected reliable data and analysed it. Staff could not always find policies they needed to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. The service regularly reviewed quality performance which managers discussed at meetings. Managers shared this information electronically with staff through minuted meetings to ensure their awareness of where improvements in performance could be made.

However, staff could not easily access policies or audits on the IT system when asked. This means that staff may not be able to follow up to date practice and guidelines set by the hospital and may affect patient care and safety.

For overall hospital information management, please see surgery report.

Engagement

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

The hospital engaged with patients and staff to plan and manage services. The organisation engaged with patients using feedback forms and questionnaires. Changes had been made based on this feedback, for instance the department created new patient quiet room for patients to socialise following recommendations in responses to a patient questionnaire. There were also ‘you said’ ‘we did’ notice boards showing the changes that had been made following patient suggestions.

Good

Medical care (Including older people's care)

For overall hospital engagement, please see surgery report.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

The oncology service did not participate in any research directly but treated patients who were participating in research in other hospitals. Staff said they could access research findings if they needed to and were able to attend additional learning if it demonstrated benefits to patient care and the hospital.

Good

Outpatients

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

Are Outpatients safe?

Good

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

Mandatory training

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

Nursing staff received and kept up-to-date with their mandatory training. The service completed training via online or in person depending on the topic. Staff completed 27 mandatory training topics during induction and at intervals of up to three years. This included fire safety, health and safety, information governance and manual handling.

Training compliance was reported as 100% for all staff for all topics. This was above the target of 90%.

Medical staff received and kept up-to-date with their mandatory training. Mandatory training was largely provided by the consultant's host NHS acute trust. As part of the regular review with the hospital, consultants also evidenced compliance with mandatory training. Any site specific training was completed as part of staff's induction and as processes were updated.

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

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

Safeguarding

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

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

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

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

Cleanliness, infection control and hygiene

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

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

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

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

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

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

The service performed well for cleanliness. Cleaning audits were completed at regular intervals and we saw that that all infection control and prevention audits showed compliance of 100% and in line with target.

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

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

Good

Outpatients

Environment and equipment

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

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

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

Resuscitation equipment was easily accessible and we saw this was checked daily and compliance audited. Hospital data showed that resuscitation equipment had been checked 100% between November 2021 and January 2022.

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

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

Assessing and responding to patient risk

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

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

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

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

The service did not routinely provide treatment to patients with known mental health conditions, although staff knew how to access support if there were any concerns. Staff shared key information to keep patients safe when handing over their care to others. Once patients had been seen in clinics, information was shared with the rest of the hospital teams who would be responsible for completing the patients care pathway.

Good

Outpatients

Staffing

The service generally 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 generally reviewed and adjusted staffing levels. Managers adjusted the skill mix, and gave bank, agency and locum staff a full induction.

The service generally had enough nursing and support staff to keep patients safe. However, the service had high vacancy rates, given the workload and patient turnover. Further, leaders told us they were not always able to attend hospital wide meetings because they did not have cover.

At the time of our inspection, there were two registered nurse vacancies, one vacancy for operations manager, and one physiotherapist vacancy. The service had medium to low rates of bank (20%) nurses and low rates of agency nurses (2%). Where possible, they limited their use of bank and agency staff and requested staff familiar with the service to ensure consistency. However, staff members told us they felt under pressure due to limited staffing levels.

The service had very low sickness reported for clinical staff from October 2021 to January 2022. However, staff told us they did not feel it was possible for them to call in sick as needed due to reduced staffing levels and lack of contingency plans.

Managers made sure all bank and agency staff had a full induction and understood the service. We were told that agency staff followed the same induction process as new members of permanent staff.

Medical staffing

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

The service had enough medical staff to keep patients safe. Consultations and appointments were arranged according to the doctor's availability. Consultants would inform the hospital of when they were available for clinics and then appointments were scheduled accordingly. Some consultants maintained regular clinics which meant that the booking team were able to plan appointments well in advance. Others provided, less frequent clinics, which would be slotted into the calendar as available. We saw that medical staffing matched the planned number. Staff reported that there were no occasions where clinics could not be accommodated.

Following acceptance into the service, consultants worked under practicing privileges

Records

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

Patient notes were comprehensive and all staff could access them easily.

Records were held on site and collected prior to any appointments to ensure they were available for the consultation. Staff reported that notes were always available for appointments.

Records were stored securely. We saw that notes were not left in any public areas. Patient notes were transported between departments securely and not left unattended. Nursing staff told us that they would place patients notes in consultation rooms prior to their appointment. Doctors clarified patients details prior to commencing the appointment.

Good

Outpatients

Clinic lists were held at the reception desk and names crossed off when arriving and when entering consultation rooms to keep track of which patients had been seen. All lists were held in files at the reception desk to prevent unauthorised access.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The majority of medicines used were local anaesthetics which were used for some clinical procedures. These were stored securely and checked in line with best practice when used.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicines were stored in the treatment room which was secure at all times. Emergency cardiac arrest and anaphylaxis medicines were kept on the resuscitation trolley and were checked daily. Anaphylaxis is a life-threatening allergic reaction that requires immediate treatment.

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

Incidents

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

Staff knew what incidents to report and how to report them. The service used an electronic reporting tool which was accessible to all staff. Hospital data showed that incidents were reviewed and investigated in a timely manner. We reviewed five incidents across the hospital and did not identify any concerns.

Staff raised concerns and reported incidents and near misses in line with provider policy. We saw that there were a variety of incidents reports which included actual and near misses. All incidents detailed actions taken in response and resolution.

The service had not recorded any never events in the past 12 months. Managers shared learning with their staff about never events that happened elsewhere. We were given examples of how incidents and their findings had been shared across the site, hospital and wider organisation. There were flash reports at daily huddles which outlined any actions that needed completion.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Although staff reported that there had been no serious incidents within the department, they were familiar with duty of candour and knew how to apply it.

Staff met to discuss the feedback and look at improvements to patient care. Staff attended team meetings and discussed how services could be improved. When attendance at team meetings was not possible, key information was shared through emails or newsletters. We saw a variety of media used across the department which all referred to learning from incidents and improvements needed for patient care.

Good

Outpatients

Are Outpatients effective?

Inspected but not rated

We did not previously rate effective. We continue to not rate effective in Outpatients, according to our current methodology.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance, such as The National Institute for Health and Care Excellence (NICE) guidelines. We reviewed a number of policies and saw that these reflected best practice and were in date. Clear review dates were set and there was a robust process for ensuring policies were reviewed.

In addition to policies, the service had a number of standard operating procedures (SoPs) which were all based on current guidelines and reviewed regularly. Policies and SoPs were accessible in paper copies (for key items) or via the intranet. Staff told us they were encouraged to use electronic versions as reference as these were the most up to date and prevented old information being used. Heads of department would replace any policies or SoPs in paper format when they were updated.

Staff we spoke with knew about the Mental Health Act and the Mental Capacity Act and had completed dedicated training. Staff were able to provide examples of supporting patients with complex mental health needs, and also gave us clear examples of discussing, obtaining and documenting consent.

Staff audited practice and monitored outcomes to ensure staff followed guidance.

Nutrition and hydration

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

Patients received information to advise them about timescales for when they could eat and drink in advance of any invasive procedures. This was provided in the appointment letter. We observed reception staff informing patients of any preparation required before their procedure in relation to food and drink.

Water cooler and coffee machines were available in the waiting rooms for patients and those who accompanied them.

There was a café available for patients to use in the hospital. The menu included diverse options to cater for the patients' cultural and religious needs.

Good

Outpatients

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff did not routinely administer pain relief in outpatients, unless patients were undergoing a procedure, when some pain relief medicines may be given. Pain was discussed at most appointments, and actions taken appropriately to address patients' pain. Staff had materials to assess pain for patients with communication or learning difficulties. Patients received pain relief soon after requesting it during outpatients procedures.

Patient outcomes

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

Whilst the outpatient department did not specifically monitor patient outcomes, the other specialties such as surgery contributed towards Patient Reported Outcome Measures (PROMS) to assess the quality of care delivered to patients in hip and knee replacements.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers shared and made sure staff understood information from the audits. We saw that audit results were discussed across all areas of the service. This included at departmental meetings, performance review meetings and as part of the organisational performance monitoring.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff were skilled to manage the workload and used competencies to confirm skills.

Managers gave all staff a full induction tailored to their role before they started work. There was a robust induction process which included orientation and escalation processes to ensure staff were familiar with the environment and processes used by the service. Agency staff completed the same induction process to promote safety and consistency. Managers supported staff to develop through yearly, constructive appraisals of their work. All staff told us that they had completed an appraisal within the last year. The appraisal rate for the service was reported as 100%.

Medical revalidation was completed at the consultant's host organisation. Consultants were responsible for ensuring that revalidation information was shared with the service, and this was tracked to ensure compliance. Any staff member with out of date revalidation was not permitted to work until it had been completed. This was monitored through yearly appraisal processes, and also discussed during regular medical advisory and governance meetings.

Consultants capabilities and performance was monitored through the medical advisory committee (MAC) and any concerns were flagged and addressed accordingly. Consultants were not permitted to complete any procedures which they had not been deemed competent to complete. The MAC approved all procedures prior to them being completed within the service.

Managers made sure staff attended team meetings or had access to full meeting notes when they could not attend. We saw that meetings were not always well attended by staff, due to staffing levels. However, the minutes were sent electronically to all staff to enable access.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff reported that they were given time and were supported to develop. Managers made sure staff received any specialist training for their role. We were given examples of how staff had attended additional training to develop.

Further, in order to address low staffing levels, managers had developed an upskilling program for staff members, which they could access freely, if they felt confident and willing to. Staff felt very positive about the opportunities this program offered.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Regular daily and monthly multidisciplinary meetings were held to ensure the hospital staff worked together for the benefit of all patients.

Nursing staff confirmed they generally had good working relationships with consultants and could easily ask for help. However, there had been instances where collaboration with the consultants became difficult. Staff came together and were proactive to develop new ways of working to address concerns on both sides. At the time of our inspection, they had trialled some new ways of working which all staff felt positive about. They also had good relationships with the imaging team and physiotherapy team. They had quick access to diagnostic test results, which were saved on the electronic system and accessible to all staff in the outpatient's department.

Patients could see all the health professionals involved in their care. There were boards introducing the team in the waiting areas.

Staff worked across health care disciplines and with other agencies when required to care for patients. We were given examples of where patients had not been suitable for their planned procedure at the hospital and how these patients were discussed with peers from the local acute hospital trusts. Staff also told us how other agencies/ speciality staff could be accessed to gain support for more complex patients.

Seven-day services

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

Staff could call for support from doctors and other disciplines. The service was available from 8am to 8pm Monday to Fridays.

Staff told us they were as flexible as possible to meet the demands on a service and to meet patients' needs and availability. Patients attending an appointment could also attend the diagnostic imaging department for further tests and staff completed blood testing and swabbing at the same time to limit the need for repeated attendances.

Health promotion

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

Good

Outpatients

The service had relevant information promoting healthy lifestyles and support in patient areas. We saw that patients were regularly offered support to live healthier lives. This included signposting to smoking cessation and prompts for reducing alcohol consumption. There were numerous posters throughout the department, including the physiotherapy area where we saw four posters to help patients undergoing physiotherapy better understand the steps and risks involved.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

All staff had completed training on consent and DoLS as part of their mandatory module. Staff gained consent from patients for their care and treatment in line with legislation and guidance. The service audited consent forms to ensure that they were completed fully, detailing potential risks, the procedure planned and that they were signed and dated. Audit results we looked at indicated compliance over 90%. Consent was discussed within outpatient appointment for treatments or procedures completed within the department.

Staff clearly recorded consent in the patients' records. Consent forms for all procedures completed in outpatients were completed at the time and reflected discussions of risk. Staff were able to describe conversations and processes for ensuring consent was gained prior to treatments.

Are Outpatients caring?

Good

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We were told that appointments were designed to enable sufficient time for discussion and questioning and patients verified that staff used this time to answer questions. This was also reflected in the patient feedback we reviewed.

Patients said staff treated them well and with kindness. We spoke to three patients who felt the level of care they received was impressive.

Staff followed policy to keep patient care and treatment confidential. All information was kept securely, with medical notes in rooms with doctors and any expected patient lists. All discussion were held in rooms which prevented unauthorised persons overhearing key personal information.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We were given examples where patients' past

medical history of a mental health condition were discussed sympathetically, resulting in consideration for a procedure at the hospital. Staff told us that the patient would have been transferred to an acute hospital for their procedure if staff had not identified coping mechanisms to enable the patient to be safely treated on site. The reported outcome was positive for the staff and patient.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. The service provided care and treatment for a diverse population and employed staff from a number of different cultures or religions. Staff expressed that they were able to meet the demands of patients through understanding of their needs from discussions. Staff gave us examples of supporting patients who required female doctors, as well as alternative foods, such as halal.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. All patients we spoke with, and information included in the patient feedback forms, evidenced that staff took time to support patients who felt anxious about their procedures. Further, staff told us about instances where they cared for patients from minority backgrounds who had specific religious needs.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff gave us examples where they went above and beyond to support patients with concerning diagnoses through their entire journey and ensure continuity of care. Patients gave excellent feedback following these experiences.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff used plain language to ensure patients understood what was happening. Staff told us that they explained treatment and plans clearly with patients and / or their relatives. Staff extended appointments where necessary to ensure patients fully understood what was happening.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Patients said they were given explanations about their treatment. They said staff explained procedures and obtained their consent before any treatment. Patients told us the consultants were thorough, they spent time explaining procedures to them and they felt comfortable and reassured. They felt they were given clear and adequate information.

Patients we spoke with reported clear communication, and we observed staff being friendly and considerate when speaking to patients and their relatives.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We observed numerous feedback forms available in the department, as well as a board with "thank you" cards from patients.

Good

Outpatients

Are Outpatients 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.

Managers planned and organised services so they met the changing needs of the local population. We reviewed the up-to-date Equality and Diversity policy, and found it was detailed, followed national law and guidance, and contained inclusive language. We also reviewed equality impact assessments that the service had in place for their internal policies and found them to be thorough and accurate.

Further, the service supported the local NHS Trust to ensure patients were cared for during the pandemic.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. Patients attending the clinic were able to see other services while attending the centre. Blood testing, swabbing and diagnostic imaging were available on site along with a pharmacy which provided prescription and non-prescription medicines.

Facilities and premises were appropriate for the services being delivered. Consultation rooms were large enough to enable patients and clinicians to attend. Each room was screened by curtains from any escorts. Chaperones were also offered for any patient attending appointments on their own, who may require a physical examination. We also observed many posters making patients aware of their right to request a chaperone.

Managers monitored and took action to minimise missed appointments. We saw that patients were sent reminders of appointments and were able to make appointments to suit their schedule. Missed appointments were minimal.

Managers ensured that patients who did not attend appointments were contacted. Staff gave us several examples where, following a missed appointment, the team would contact patients to identify why they had missed their appointment and offer an alternative slot.

The service relieved pressure on other departments when they could treat patients in a day. The service provided some clinical procedures, which were planned in advance to prevent repeated attendances. Staff told us that patients usually attended a consultation appointment and were then offered a date and time for their procedure to be completed within one week. This enabled patients to prepare for their tests.

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

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

Good

Outpatients

Meeting people's individual needs

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

Staff gave us several examples of supporting patients with protected characteristics. Protected characteristics according to the Equality Act 2010 are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. Staff we spoke with displayed knowledge and understanding of the training on equality and gave examples of how they applied this learning.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. All staff we spoke with had completed their dementia training and were familiar with AIS (Accessible information standards). Staff also gave us examples of supporting patients who needed longer appointment slots.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. All staff we spoke with gave us examples of supporting these patients. All clinic and treatment rooms were suitable for use by patients attending who required walking aids. There were low level reception desks, and a lift for use. Public toilet facilities were available for those requiring walking aids or wheelchairs, and there was ample disabled parking close to the entrance. The reception area included hearing loops.

The service had information leaflets available in languages spoken by the patients and local community. The service had information leaflets available in languages spoken by the patients and local community. Although all information leaflets in the department were in English, staff told us they could be printed in other languages or larger print. On initial referral to outpatients, staff would ensure that communication was possible with the patient at their appointment, which included translation service if needed.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. All staff we spoke with gave us examples when they used interpreting services and demonstrated they knew how to use them when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff we spoke with told us they discussed these aspects with patients and made efforts to accommodate all these needs.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. All patients we spoke with said it was easy to make an appointment and were seen quickly on their arrival at the department. Staff we spoke with gave us examples of how they tried to suit the patients' needs and availability. All patient feedback we obtained and reviewed indicated satisfaction with waiting times. On average, from the patient feedback we reviewed, waiting times did not exceed one week.

Managers worked to keep the number of cancelled appointments to a minimum. Staff told us of one occasion in the past six months when a clinic had been cancelled due to changes to the consultant's availability.

Good

Outpatients

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. We saw that cancelled clinics were very rare and patients in these exceptional situations were moved to another suitable date and time. Consultants either emailed or called the hospital to cancel lists. Did not attend (DNA) patients were recorded on the tracker which staff could access.

Clinic waiting times were closely monitored. When a consultant was running late, staff called patients to advise. Consultants made efforts to reduce the impact on patients during the clinic.

Managers and staff worked to make sure that they started discharge planning as early as possible. Discharge plans would be discussed as part of the preparation for theatre, with staff informing patients of the expected number of nights in hospital, recovery period and any impact on their wellbeing. For example, patients attending for knee surgery, were informed of the follow up appointments and need for physiotherapy following discharge from hospital, prior to attending for the procedure.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. We saw patient feedback forms available in several areas of the department. Additionally, there were many posters with information on how to provide feedback electronically, on the website.

Staff understood the policy on complaints and knew how to handle them. All staff we spoke with were aware of the complaints policy, and reported discussing patient and carer feedback. We reviewed complaints data and found that 100% had been upheld. The service followed the internal complaints policy and targets, as well as national guidance.

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service.

We looked at minutes of clinical governance and departmental meetings and saw that they included learning from complaints.

Are Outpatients well-led?

Good

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

Leadership

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

Good

Outpatients

The Outpatients Clinical manager was very visible and accessible, and staff reported that they felt comfortable in escalating concerns to any senior member of staff. Service leads had open door rules and encouraged staff to “drop in” if they wanted to talk about anything.

However, staff told us that limitations in staffing levels had been mentioned to the leaders repeatedly, and no action had followed.

We raised this with the Provider who confirmed their commitment to improving communication on recruitment and wider initiatives around staffing.

Vision and Strategy

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

The service followed the Circle Health Group clinical strategy which had been reviewed in 2021 and was focused on “providing high quality, safe and compassionate care” to patients. There were three key areas of focus which included clinical quality, patient safety and medical and clinical governance.

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

Culture

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

Staff we spoke with were positive about their roles and enjoyed working for the organisation.

Staff were positive about their jobs and worked collaboratively with their peers. We saw that staff adopted practices to support each other when activity increased ensuring tasks were completed in a timely manner.

Staff said the management team did a ‘walk around’ but not on a regular basis. Staff told us hospital managers were generally approachable, but not visible.

Staff felt comfortable raising any concerns and staff generally felt that something would happen if they escalated concerns. They gave us examples of when they felt unhappy and raised concerns, which their immediate managers took into account and acted on. Staff told us they were not discriminated against after raising concerns. However, staff told us senior leaders did not always act promptly in response to concerns they raised about culture.

Staff also felt encouraged to develop and told us they were given opportunities within the organisation or externally if possible, to develop new skills or gain knowledge.

The service promoted equality and diversity and it was part of mandatory training. Managers and staff promoted inclusive and non-discriminatory practices.

Good

Outpatients

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations.

There was a robust governance structure. There was a variety of meetings which enabled the escalation of any issues or concerns to the senior leadership team. We saw that each meeting was clearly minuted and actions recorded. There was a clear pathway of escalation to the senior leadership team and the wider Circle Group organisation. The reporting structure enabled oversight of all services and a standardisation of information.

Outpatients meetings took place every morning, and included discussions around incidents, learning, improvement and future vision, as well as additional training needs from staff.

For our detailed findings on governance please see the Well led section in the surgery report.

Management of risk, issues and performance

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

There was an audit programme which monitored compliance against standards. We saw that there were several outpatient specific audits which included physiotherapy documentation, surgical safety checklist- observational audit, environment checks and infection prevention and control.

The outpatients department was included in the overall hospital risk register. Risks were graded according to their potential harm. Any significant risks were added to the hospital risk register, whereas low risks were managed by the local teams.

Heads of department were held responsible and accountable for their department. We were told that HoDs had performance meetings with the senior leadership team to review performance, compliance, staffing, and any concerns.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Staff knew how to escalate risks internally and externally and felt that systems were in place to facilitate that.

Staff completed general data protection regulation (GDPR) and information governance training and were familiar with how to maintain information security.

For our detailed findings on managing information please see the Well led section in the surgery report.

Engagement

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

Good

Outpatients

The service completed monthly satisfaction surveys. Data from the previous three months showed that 100% of patients attending the outpatient services had a good or very good experience, which was above the organisations average. Results of the patient survey were on display in public areas in the department.

Where possible, the service worked with nearby organisations to ensure patient care and treatment. On occasion, staff had referred to local services to gain support for patients or refer to them due to being inappropriate for the service.

However, staff told us they did not feel listened to, particularly when flagging issues around staffing.

We raised this with the Provider who confirmed their commitment to improving communication on recruitment and wider initiatives around staffing.

For our detailed findings on engagement please see the Well led section in the surgery report.

Learning, continuous improvement and innovation

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

There was a focus on continuous learning and improvement. The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.

Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Theatres provided cover for the minor ops room when the outpatients department was very low staffed.

For our detailed findings on Learning, continuous improvement and innovation please see the Well led section in the surgery report.

Good

Surgery

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

Are Surgery 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.

Staff received and kept up to date with their mandatory training. Managers monitored mandatory training and alerted staff when they needed to update their training. Staff compliance with mandatory training was 99.5% for December 2021 which met the provider's compliance target of 90%.

Mandatory training was comprehensive and met the needs of patients and staff. The hospital followed the Circle Health Group mandatory training policy which defined the mandatory training requirements of staff including bank workers.

Mandatory training was split into departments and job roles. Staff in the surgery service had personalised lists of mandatory training.

Staff told us there were no barriers to accessing mandatory training, although it was not always easy to find the time to complete training in their normal working hours. To mitigate this, and in line with the corporate mandatory training policy, staff could access on-line training at home.

Face to face training stopped during the COVID-19 pandemic to avoid the spread of the virus. At the time of our inspection, face to face training had restarted.

Safeguarding

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

The hospital followed the Circle Health Group safeguarding adults and safeguarding children and young people policies. These policies provided staff with guidance on how to identify abuse and the processes to follow if needing to raise a safeguarding concern.

Staff received training specific for their role on how to recognise and report abuse. Safeguarding vulnerable adults and children training figures showed 100% of eligible staff had completed training to the level appropriate for their role.

Staff received PREVENT training and 100% of those eligible had completed it. The PREVENT training covered other elements of safeguarding such as radicalisation and female genital mutilation.

Most staff had not raised a safeguarding concern whilst working at the hospital but knew who the hospital safeguarding lead was, could demonstrate what constituted abuse, and explain the safeguarding processes.

Consultants submitted evidence of their mandatory safeguarding training in their substantive post, for their practising privileges to be renewed.

The director of clinical services was the lead for safeguarding at the hospital and had oversight of any referrals made to support staff and patients.

Safeguarding information, including contact details for the safeguarding lead, were displayed throughout the hospital.

Cleanliness, infection control and hygiene

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

The hospital had infection control policies and procedures to help control infection risk. Staff followed these and other related policies to minimise the risk of infection and cross infection in the hospital and the surgery service. Managers introduced new protocols and procedures in response to the COVID-19 pandemic. This included a new procedure for anyone arriving at the hospital, and for patients who needed to home isolate and have a negative COVID-19 test before their elective surgery.

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

Staff completed twice weekly lateral flow tests, and results were recorded. The vaccination status of all staff was noted in their personnel records.

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

The service had completed a program of environmental improvements and refurbishments on both the wards and in theatres and was compliant with Health Building Note (HBN) 00-09. There were handwashing basins in all patient rooms and in the sluice room in theatres.

Theatres and the theatre suite were visibly clean and tidy. We saw suitable flooring and furnishings throughout the hospital and the surgery service was clean and well-maintained.

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

Good

Surgery

Staff followed good practice guidance and maintained clean and dirty flow within the operating theatres. This included limiting the number of staff entering the operating theatre during surgery and restricting the movement of personnel in the operating theatre to a minimum.

The service used an external contractor for decontamination of instruments off-site and for deep cleans of theatres. There was a service level agreement for the provision of microbiology between the hospital and a local NHS trust. Audits showed deep cleans took place at regular intervals. The Circle Health Group, and this hospital, used a track and trace system to trace all reusable accessories to ensure appropriate maintenance, correct decontamination and traceability to associated patients.

The hospital had recorded six surgical site infections in the reporting period October 2021 to December 2021 which was a rate of 1.79% of the total number of procedures performed at the hospital. A review of these six incidents showed all were community acquired infections.

In the reporting period September 2020 to August 2021, the service had reported no hospital acquired infections.

The infection prevention and control (IPC) lead told us they reviewed surgical site infections to see if trends could be identified and infection control improved on. We saw evidence of this in the IPC meeting minutes. Staff completed infection prevention and control training during induction and annually at the level appropriate to their role as part of mandatory training. Staff followed good general infection control practices to minimise the spread of any infection. For example, they wore face masks, were bare below the elbow and cleaned their hands before and after contact with every patient.

Staff worked effectively to prevent, identify and treat surgical site infections. As a result of the COVID-19 pandemic, the service ensured all patients were tested for COVID-19 before their admission. Patients who had joint surgery had swabs for MRSA and Methicillin-sensitive Staphylococcus aureus (MSSA). The hospital reported no incidences of c-difficile, methicillin sensitive staphylococcus aureus (MSSA) and MRSA between January to December 2021.

Housekeeping staff were responsible for cleaning patient and public areas in accordance with daily and weekly checklists. Cleaning records were up-to-date and demonstrated areas were cleaned regularly and deep cleaned when needed. Cleaning equipment was stored securely in locked cupboards. Unauthorised persons could not access hazardous cleaning materials.

Staff used *I am clean* stickers on equipment in the clinical areas to identify that items had been cleaned and were ready for use.

Environment and equipment

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

The service had suitable facilities to meet the needs of patients and enough suitable equipment to help them to safely care for patients.

Good

Surgery

There were two operating theatres, which both had laminar flow to help reduce the incidence of surgical site infections. Each theatre had a preparation and attached anaesthetic room. The theatres were bright, appeared clean and were generally in a good state of repair. Managers highlighted their concerns regarding the ageing fabric of the building and old air conditioning units within the theatre environment. These issues did not pose a specific patient safety risk, however they were listed on the service risk register as they required investment and building works to improve.

The recovery area had space for three trolleys for patients recovering from surgery. All were equipped in line with Association of Anaesthetics of Great Britain and Ireland (AAGBI). Staff only used two bays to help maintain social distancing.

Access to the theatre suite was not restricted by locked doors. Staff sat at a ward reception desk which was situated at the entrance to the corridor for the theatres. They were able to maintain oversight of who entered the corridor. However, staff were not always at the desk. Theatre staff challenged people they did not recognise. The service had recognised the risk and had plans to install electronic swipe card/fob technology. This was listed on the service risk register and no incidents regarding unauthorised access had been recorded.

Staff carried out daily safety checks of specialist equipment in theatres. For example, anaesthetists checked the anaesthetic machine, signed and dated the logbook and recorded the number of breathing circuits. We looked at the resuscitation trolleys and found equipment was available, ready for use and had been checked regularly. Stickers on medical equipment in theatres and on the wards indicated they had been maintained and were within their service date.

The theatre suite had a difficult airways trolley. However regular safety checks of the trolley and equipment had not been done. We highlighted this to the hospital management team, who took immediate action to address the issue. The trolley and equipment were new, and no items were faulty or out of date, so there were no patient safety concerns. Service leads drafted and instigated a new safety checklist and new procedure for this trolley. Managers implemented the new procedure before the end of the onsite visit.

Staff on the ward carried out safety checks of the resuscitation trolley. Records showed staff carried out equipment checks which demonstrated a consistent and regular approach to safety checks. However, staff did not follow hospital policy on how to carry out the checks on every occasion. The policy required the numbered tamper proof tag be removed once a week and the entire contents of the trolley checked. A new numbered tag would be installed, and the corresponding number recorded on the checklist. We found for three weeks during January 2022 staff had not removed and replaced the tag. Meaning the contents of the trolley could not have been checked. We highlighted this to the hospital management team who immediately reviewed the situation and put in place mitigations to ensure this would not reoccur. We checked the trolley and confirmed there was not any out of date or faulty equipment.

There was one ward with 32 single rooms for inpatient and day case surgical patients. In addition, there was a close observation room with capacity for two bed spaces.

All rooms had been refurbished and included wet rooms.

Patients said they could reach call bells and staff responded quickly when called. There were emergency call pulls in each patient room and easily accessible resuscitation trolleys for staff to use in the case of an emergency.

Staff kept cleaning, storage cupboards and utility rooms locked and secured at all times. This meant access to areas unsuitable for patients was controlled.

An onsite maintenance team kept records of equipment across all departments, this included service history and electrical testing. Random checks of equipment in the theatre suite and on the wards showed all items had a label indicating it had been checked for electrical safety and had been serviced. This provided the assurance that equipment was safe to be used.

Staff said they had enough equipment to provide safe and effective care and treatment to patients. We checked a sample of consumable items for expiration dates and all were in-date. Storerooms were tidy, well organised and items stored correctly according to policies and procedures. This meant consumables were easily located for staff.

There was a tracking system for recording and reporting of specific implants and equipment to the national joint registry. We saw all equipment, implants and prosthesis were tracked and traced. All records had clear evidence of this with batch numbers recorded.

Staff understood their responsibility to ensure they segregated and disposed of clinical waste according to the hospital's waste management policy. We saw management of containers for sharps and the use of coloured bags to correctly segregate hazardous and non-hazardous waste. Staff removed clinical waste from the clinical areas at regular intervals to reduce infection control risks. An external supplier was contracted to dispose of clinical waste.

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

Patients undergoing elective surgery had a pre- assessment to ensure they met the inclusion criteria for surgery and key risks were identified that may lead to patient's complications during the anaesthetic, surgery, or post-operative period. Registered nurses with specific training carried out the assessment. Staff used the opportunity to fully inform patients about the surgical procedure and the post-operative recovery period.

The hospital admission criteria meant the hospital only admitted patients the hospital had facilities to care for. Patients with complex co-morbidity and bariatric patients were not routinely admitted for treatment. The service considered admission exceptions on the presentation of all relevant clinical evidence.

The service had developed pre- and post-surgery principles and procedures during COVID-19. Staff followed clear elective surgery pathways which had been instigated during the pandemic.

The service used criteria to determine which patients received virtual assessments or face-to-face assessments. For example, patients undergoing a local anaesthetic would normally have a telephone pre-assessment. Patients having a general anaesthetic would be assessed in a nurse led pre-operative assessment clinic at the hospital.

Nurses swabbed patients at pre-assessment to assess for MRSA as per hospital policy. They provided patients who tested positive with a treatment protocol to use at home before surgery. If necessary, surgery would be deferred until the patient had a negative swab result.

Staff completed risks assessments for patients on admission to the hospital using national recognised tools. These assessments included risks of malnutrition, fall risk assessment, venous thromboembolism (VTE) and known allergies. Staff used care plans containing this information to provide care and treatment and minimise risks as identified. Patients with known allergies wore a red wristband. This alerted staff to the patient's allergic status and helped mitigate the risk of allergic reactions.

Good

Surgery

Staff in theatres had processes to keep people safe and used the World Health Organisation (WHO) safety checklist for surgery. The WHO checklist is a nationally recognised system of checks designed to prevent avoidable harm and mistakes during surgical procedures. The service monitored compliance with WHO five steps to safer surgery which showed good compliance. However, we witnessed one sign-in process which was not completed as per hospital policy, as not all staff required to be present were there.

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

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

Shift changes and handovers in both theatres and on the ward included all necessary key information to keep patients safe. Staff of all levels knew their role in identifying and responding to sepsis.

Staff had immediate access to blood products, to stabilise patients with life threatening haemorrhage. Staff checked and recorded the blood fridge temperature and stock daily.

We observed patients being transferred from theatre to the recovery area, and saw the anaesthetist, surgeon and scrub nurse verbally hand over the care and treatment carried out in theatre. Staff discussed medication which had been prescribed for both recovery and the ward.

Theatre staff attended a safety huddle each morning, where the operating team discussed the operating list. They highlighted and planned for any potential patient risks or issues. Staff printed theatre lists on white paper. However, if any changes had been made to the list they were reprinted onto green paper which gave staff a visible reminder that something had changed.

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

All clinical staff were adult intermediate life support trained and the RMO, who was on site 24 hours a day, was trained in advanced life support.

All staff were required to respond in the event of a patient emergency. There were no prior agreed roles. However, the RMO was always assigned as the team leader. Other roles would be assigned upon arrival to the scene. Senior managers onsite carried a bleep and would also respond to emergency calls.

Good

Surgery

The hospital also undertook unannounced resuscitation scenarios carried out by an external company. These tested and assessed staff emergency reactions to scenario-based situations. We reviewed the latest resuscitation scenario report, from December 2021, produced by the external training company. The report described how staff performed during the scenario to a high standard.

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

Staffing

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

The service had enough staff to keep patients safe. The hospital used a corporate staffing tool that had the ability to plan and track the staffing activities of the day and therefore provide staffing to match. The ward manager could adjust staffing levels daily according to the needs of patients.

The service staffed the ward and theatres appropriately to ensure the right staff were on site to provide appropriate care and treatment. Patient admissions were known in advance and staffing levels calculated to ensure safe staffing levels were planned according to the number of patients using BMI staffing guidance and best practice.

Theatre managers ensured there were adequately skilled staff to manage the elective surgery list. Theatre managers followed the Association for Perioperative Practice (AFPP) guidelines. The AFPP recommended minimum theatre staffing levels of two scrub practitioners, one circulating staff member, one registered anaesthetic assistant practitioner and one recovery practitioner for each theatre list. Records showed theatre staffing met these recommendations. Senior theatre staff told us they reviewed their staffing daily to ensure the theatre list could go ahead.

The hospital calculated staffing levels on the ward using an evidence based electronic patient acuity and dependency monitoring tool. The tool could be manually adjusted to take account of individual patient needs. On the day of our inspection we saw the ward had enough staff as planned to ensure safe staffing.

The hospital reviewed staffing across the wards and theatres daily during the morning communication cell meeting by the executive director and interim director of clinical services to ensure allocation of resources met the clinical needs of patients. Plans would be put in place to ensure services were staffed safely, for example approving the need for additional staff or cancelling a surgical list if needed.

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

Medical staffing

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

Patients were admitted to the hospital under the care of a named consultant.

Good

Surgery

Consultants led and delivered the surgical service at the hospital under practising privileges. Practising privileges are a well-established process within independent healthcare, whereby a medical practitioner is granted permission to work in an independent hospital.

Consultants followed a process when applying for practicing privileges at the hospital. The hospital had a medical advisory committee (MAC) for governance of doctors working in the service to ensure they continued to meet the standards to practice at the hospital.

All consultant surgeons and anaesthetists had to complete an application for admitting rights. The hospital management team used the information to determine whether the person had the required skills and experience to carry out treatments at the hospital. Consultants had to demonstrate competence to perform the procedures included as part of their practising privileges and were working within their normal scope of practice. Medical staff who could not demonstrate they had the relevant skills were not granted practicing privileges.

There were robust processes in place for reviewing practicing privileges at the hospital. The hospital's executive director reviewed individual consultants' practicing privileges every two years. Although mandatory training and appraisal information were reviewed yearly.

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

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

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

The RMO provided day to day medical cover 24 hours a day, seven days a week, on a rotational basis. RMOs were employed through a formal contract with an agency. They worked a two weeks on two weeks off rota. This ensured their duty weeks were balanced with consolidated periods of rest.

The RMO was the doctor responsible for the care of the patients in the absence of the consultant. They provided support to the clinical team in the event of an emergency or with patients requiring additional medical support. The RMO was trained in advanced life support and held a bleep for immediate response, for example, in the case of cardiac arrest. Nursing staff told us the RMOs were approachable and responsive when required.

Records

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

Good

Surgery

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

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

We saw evidence in the patient records of ward to theatre handover and theatre checklists completed. This ensured continuation of patient care between the teams. Where appropriate, patient care records contained stickers identifying equipment and implants used during surgery. This meant that they could clearly be tracked and traced.

Records were stored securely in a locked room or in areas only accessible to authorised staff. Staff requested records from the medical records department and told us they were supplied to them in a timely way.

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

Consultants wrote discharge letters outlining treatment provided. They sent a copy to the patient and their GP. Discharge letters included post-operative instructions for both the patient and GP. This ensured continuation of patient care.

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

Medicines

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

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

Pharmacy technicians undertook a stock check of medicines which ensured stock levels were adequately maintained.

On the ward and in theatres, all medicines we checked were within date and stored appropriately. We found controlled drugs were stored correctly in locked cupboards and fridge temperatures had been checked and logged daily. However, in an anaesthetic room there were controlled drugs drawn up for a patient in an unlocked cupboard. This was not in line with hospital policy regarding the safe storage of controlled drugs. This was highlighted to staff at the time who immediately locked the drugs away.

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

Good

Surgery

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

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

Incidents

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

Staff raised concerns and reported incidents and near misses in line with the Circle Health Group incident management policy. The policy included definitions of incidents and their level of harm and how incidents should be reported, investigated and actions taken.

Staff knew what incidents to report and how to report them using an electronic incident reporting system.

Staff discussed incidents reported the following day at the daily communication cell meeting. Representatives from each department were present at the meeting which meant feedback and issues from incidents could be cascaded quickly. Staff said they received feedback from investigations of incidents that had occurred both internally and in other BMI hospitals.

The service had not had any never events in surgery in the six months before 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 to have happened for an incident to be a never event.

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

There was a Circle Health Group policy about being open and duty of candour. It was the responsibility of the senior management team to ensure the principles of the duty of candour had been completed. Staff in theatres and the ward understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We saw examples where duty of candour was discussed at clinical governance meetings.

Patient safety alerts were a set agenda at the monthly governance meeting. Heads of departments ensured actions from patient safety alerts were acted upon where needed and information shared with staff.

The service continually monitored safety performance and displayed data on wards for staff and patients to see. The hospital had a system to monitor pressure ulcers, falls, venous thromboembolism (VTE) and infection rates.

The hospital collected this data from patients and used it to monitor performance and put in place measures to improve patient care. The hospital wards displayed the safety information for patients and visitors to view.

Good

Surgery

The service had a good track record on providing harm free care. They had no incidents of falls with harm and hospital acquired pressure ulcers.

Are Surgery 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. Policies and guidelines had been developed in line with the Royal College of Surgeons, Royal College of Anaesthetists, and National Institute for Health and Care Excellence (NICE) guidelines.

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

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

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

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

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

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

Nutrition and hydration

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

Good

Surgery

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

Nursing staff asked patients about any food intolerance or allergies as part of their pre-assessment. This also included specific dietary or cultural requirements, such as vegetarian or halal. Staff provided patient dietary information to the catering team so suitable food was provided during their stay.

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

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

Patients had access to hot and cold drinks and meals, and we saw they were presented well. Staff told us patients were offered support with food and fluids, although most patients did not require assistance.

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

Pain relief

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

Patients had access to a variety of pain relief as appropriate for their surgery. Staff completed regular assessments to ensure that patients' pain was controlled and administered pain control as prescribed. Staff also prescribed anti sickness medicines to manage the side effects of some pain-relieving medicines if required.

Patients told us their pain was managed well and pain relief was available to them when they needed it. Patients told us they received pain relief soon after requesting it. Staff assessed patients' pain and gave pain relief in line with individual needs and best practice. Staff used a numerical scoring system to assess pain.

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

Patient outcomes

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

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

Good

Surgery

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

Data from these audits provided an indication of the outcome or quality of care delivered to patients by the service.

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

We reviewed data submitted to these audit programmes and saw outcomes for patients were overall positive and met national standards.

The service participated in the hospital's audit programme which demonstrated compliance and identified areas to improve patient care, treatment and outcomes. The hospital monitored and discussed results from audits at the hospital's monthly clinical governance and medical advisory committees, as well as at a regional and corporate level. The hospital fed back actions to departments as required. We reviewed minutes of team meetings which confirmed this.

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.

All staff with a professional qualification were subject to pre-employment checks to ensure their professional qualification was active with no restrictions in place.

Staff had relevant experience, were qualified and had the right skills and knowledge to meet the needs of patients. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff completed competency training depending on their role and the area they worked in. This ensured staff had the appropriate skills and knowledge to manage patients safely and effectively. Each member of staff, including bank staff, had their own training folder where they kept evidence of training taken and completed competency training.

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

Staff described how they could access training courses to support their professional development. Noticeboards displayed training courses available to staff.

Managers supported staff to progress through regular development meetings and yearly appraisals of their work. Staff had the opportunity to discuss training needs and managers supported them to develop their skills and knowledge. Staff told us they were encouraged to identify any learning needs they had, and any training they wanted to undertake to develop their practice.

Managers also identified poor or variable performance through the appraisal process, complaints, incidents and feedback. Managers supported staff to improve their practice where indicated or required.

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

Multidisciplinary working

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

The hospital had a daily communications cell meeting, which took place every morning at the same time. Senior management team and a representative from each department in the hospital attended the meeting. All staff contributed to provide an overview of the hospital's activity. They took back relevant information to each department and cascaded to the team. Management and staff described the meeting as an opportunity for different teams to come together and to discuss the hospital as a whole.

We saw effective collaborative multidisciplinary working across surgery. Staff, including representatives from pharmacy, physiotherapy, nursing team and resident medical officer (RMO), held patient bedside meetings each morning. Staff discussed care plans for each patient during these meetings.

Clinicians undertook patient handovers when handing over care, for example between the consultant and RMO. Staff discussed the detail of the patient's condition, wellbeing and any potential risks.

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

Staff and patients said consultants attended their patients on ward rounds and were easy to access for information. We observed physiotherapists and the pharmacy team giving support to patients and clinical staff before and after surgery.

Seven-day services

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

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

The operating theatres operated five days a week. Theatre staff were on-call should there be any unplanned returns to theatre. They provided an on-call emergency service twenty-four hours a day and seven days a week and had an established on-call rota. Nursing cover was available on the wards when the hospital was open both during the day and overnight for patients who required an overnight stay.

Consultants undertook a daily review of their patients and either visited or telephoned the service for an update at weekends. Consultants were available out of hours, during weekends and on call 24 hours a day for patients in their care. The resident medical officer (RMO) was based on-site at the hospital and provided a 24 hour a day, seven days a week service. The RMO provided clinical support to consultants, staff and patients.

Good

Surgery

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

Health promotion

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

Patients attended pre-operative assessment appointments where staff checked their suitability for surgery. This included the completion of a health questionnaire, and an opportunity for the nurse to provide advice or refer patients on to other appropriate services if they required these services.

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

The hospital had COVID-19 safety protocols as COVID-19 was still a risk when our inspection took place. This included, as a preventative measure, limiting the number of objects in communal areas, such as patient information leaflets. However, leaflets were available via the clinical staff, consultants and allied health professionals.

The service had relevant information promoting healthy lifestyles and support. This was provided to patients on a case by case basis.

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.

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

Consultants and nursing staff gave patients information about their procedure both verbally and in writing to make an informed decision about their procedure. Patients said doctors fully explained their treatment and additional information could be provided if required.

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

Staff fully completed consent forms within the patients' records and detailed the procedure planned and the risks and benefits of the procedure. Hospital consent forms complied with Department of Health and Social Care guidance. The service had a two-stage consent process. We saw patients' records showed consent had been reviewed on the day of their surgery as part of their pre- operative checklist.

Good

Surgery

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

Are Surgery 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 throughout the surgery service put patients at the centre of what they did. During our inspection we saw positive and friendly interactions between staff and patients. Staff treated patients with warmth and care, they were courteous, professional and demonstrated compassion to all patients.

Ward and theatre staff safeguarded the patients' dignity including when they were not conscious. Staff made sure patients were covered with gowns or blankets when being transported or escorted to other areas within the hospital.

Staff were discreet and responsive when caring for patients. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients. Staff ensured patient discussions on treatment took place in private consultation rooms.

Staff always considered peoples' privacy and dignity. Staff always knocked before entering a room. The hospital used signs on the doors to inpatient bedrooms which was a discreet way of letting staff know when not to enter the room or if there was an infection risk.

Patients commented positively about the care and treatment they had received. Patients said staff were friendly, kind and treated patients with respect. Patients told us staff were professional and had asked them throughout their care if they were comfortable.

The service displayed patient satisfaction results on the ward. Results for July to September 2021 showed 99.3% of patients would recommend family and friends to the hospital. 99.7% of patients said they felt they were treated with dignity and respect at all times.

The ward displayed patient thank you cards with comments thanking the staff for their care and support during treatment.

Emotional support

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

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

Good

Surgery

Staff gave patients and those close to them help, emotional support and advice when they needed it, for example supporting patients who experienced anxiety with surgical procedures. The service offered treatment plans in line with the patients' wishes.

Staff gave examples where they had supported patients who were sight or hearing impaired, or who had sensory issues, to access care in a supportive way. This involved ensuring they documented and shared patient needs, providing one-to-one care and using a patient passport which described what the patient liked or how best they could be supported. All these resources helped to gain the trust of the patient on the day of their surgery.

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

Staff understood each patient was an individual and took time to get to know their patients. This meant they could give the right emotional support for that patient when needed.

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.

Patients said they had been involved in all aspects of their own care. We observed good interactions and relationships between staff and patients, which allowed positive informal discussions to take place. Staff communicated with patients about their care and treatment in a way they could understand.

Patients said staff were thorough when explaining what would happen and they had enough time to ask questions. Patient records showed discussions had taken place about the potential risk and complications of surgery, as well as the benefits and alternative treatment available.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients could provide feedback in the hospital or at home; they gave positive feedback about the service overall. Patient satisfaction results for July to September 2021 showed 99.3% of patients would be likely or extremely likely to recommend the hospital.

During 2021 the service had received 27 formal compliments, and several thank you cards, and some were displayed on the ward. Patients spoke positively about the staff, food, and outcomes of their care. Patients told us, and we saw, the hospital and staff did not treat NHS and non-NHS patients differently in any way.

Appointment times were flexible to accommodate individual patient needs. Time was given to go through all information including costs for those patients who were self-paying.

Are Surgery responsive?

Good

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

Good

Surgery

Service delivery to meet the needs of local people

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

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

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

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

Most patients who attended the hospital were privately funded or insured patients. In addition, the hospital also participated in the NHS e-Referral Service for certain procedures. Through this service, NHS patients who required an outpatient appointment or surgical procedure were able to choose both the hospital they attended and the time and date of their treatment.

In response to the COVID-19 pandemic, the service had taken on NHS work to support elective surgical services at a nearby local NHS trust. Primarily this was to support the cancer surgery service, for which there was also a service level agreement with the local NHS trust.

The hospital had worked closely with the local clinical commissioning group (CCG) and NHS trust to identify how the hospital could be used to provide COVID-19 safe environments to services that had been paused at the local trust. The working arrangements during the pandemic had led to stronger relationships and more collaboration between the hospital and local health community.

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 discussed surgical patients' individual needs during booking and pre-admission assessment. Staff used this information to provide safe care and treatment and mitigate risks to the patient.

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

The service assessed and highlighted adjustments for patients' individual needs during the pre-assessment. For example, patients could request a choice of food and drink to meet their cultural and religious preferences.

Good

Surgery

The hospital did not have the facilities to support the care of patients with high complex needs. Therefore, the hospital did not admit this patient group to the hospital. However, patients who lived with a learning disability or dementia could be admitted following completion of the appropriate risk assessments.

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

Staff told us they had completed dementia awareness training but rarely treated patients living with dementia. The hospital had achieved 100% completion rate for mandatory dementia training. The hospital had designed the ward to meet the needs of patients living with dementia.

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

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

Staff used the data to further improve services. Staff displayed 'You Said! We Did!' information to demonstrate how they improved the service based on feedback from patients.

Access and flow

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

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

The service did not have a waiting list as all surgery was elective and access to the service was flexible to meet patient's needs. This included variable appointment times and choices regarding when patients would like their treatment, subject to consultant and nurse availability.

The hospital had established a clear booking process for appointments and hospital admissions. Patients told us the hospital had a good and efficient booking process.

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

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

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

Good

Surgery

The hospital provided an on-call theatre team however, in the event of a patient deteriorating and requiring further intervention, they had a service level agreement with the local NHS trust to transfer patients for more complex care and treatment.

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

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.

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

The service treated concerns and complaints seriously, investigated them and learnt lessons from the results. Managers aimed to resolve patient complaints at the point of care to improve the patient's experience.

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

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

The hospital received 35 complaints during January to December 2021. Complaints content varied from lack of communication to clinical care and treatment concerns.

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

We saw evidence hospital complaints had been discussed and addressed at the clinical governance meetings and in the medical advisory committee meeting. The hospital analysed complaint themes or trends and put in actions to stop them occurring again.

Are Surgery well-led?

Good

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

Good

Surgery

Leadership

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

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

An executive director (ED) led and had overall responsibility for the hospital. The director of clinical services and the clinical chair provided support to the ED.

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

The director of clinical services managed heads of departments, which included the theatre and the ward heads of department, the infection prevention control (IPC) lead and the quality and risk manager. The ED managed the non-clinical service leads.

At the time of the inspection the director of clinical services role was interim and being filled by the CSM for the wards. The regional management team as well as the hospital ED provided additional support.

The senior management team supported staff to develop their skills. Staff told us their managers were supportive and encouraged their career progression. Staff of all grades told us the executives were visible, accessible and supportive. Leaders worked together to support and improve patient safety and patient experience.

Staff working in the theatre and the inpatient ward spoke highly about their managers and felt supported and valued. Managers were visible and approachable, and we saw evidence of this on the inspection. Staff said CSMs were available to offer guidance and said they could talk through any concerns they had. The CSMs had a good understanding on the departmental risks and challenges they faced. The CSMs said they received good support from their respective managers.

Vision and Strategy

The hospital had a vision for what it wanted to achieve and a strategy to turn it into action. Leaders and staff understood the strategy and knew how to monitor progress.

The purpose, principles and values for the hospital aligned with the Circle Operating System (COS), which had been launched in March 2021 to all BMI hospitals.

The hospital was committed to the Circle Health Group's purpose which was to provide the high quality, safe and compassionate care our patients need and expect.

There were four principles identified:

- We believe that patients come first
- We believe in our people
- We believe that "good enough never is"
- We believe in being open-minded and innovative

Good

Surgery

Underpinning the key areas were the underlying values that guided the group and its employees. Those being:

- We value people who are selfless and compassionate
- We value people who are collaborative and committed
- We value people who are agile and brave
- We value people who are tenacious and creative

Staff we spoke with during our inspection believed in the philosophy and were working to embed it in their everyday working practices. The hospital displayed the philosophy throughout the hospital and the surgery areas.

There was no specific vision and strategy for surgical services, however the hospital and service had identified a purpose, underpinned by principles and values, to support the corporate vision. During our inspection we saw these displayed on noticeboards.

Culture

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

Staff were welcoming, helpful and professional in their communication with each other, patients and visitors. Staff described good teamwork and respect amongst their colleagues. We could see this in practice when we inspected the theatre and ward areas and saw cooperative and appreciative relationships amongst staff of all grades.

Staff told us they felt supported, respected and valued in their working environments. Staff told us they felt supported as individuals in their roles but also as part of the wider hospital. Staff spoke positively and passionately about the care and the service they provided. They saw quality and patient experience as a priority and responsibility for everyone.

Staff told us the senior management team were approachable and visible and had an open door policy to discuss concerns.

The hospital had a freedom to speak up guardian to ensure staff could raise concerns in a safe and supportive way. A corporate level freedom to speak up guardian was accessible to the post holder to provide support, and they held regular meetings with other role holders in the BMI group.

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

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

Following the survey, a hospital specific action plan was drafted, with key actions assigned at corporate level, to the executive director (ED) and to the senior management team (SMT). For example, the confidence in the leadership team was identified as requiring action.

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

Good

Surgery

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

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.

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

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

Subcommittee reports, such as those from safeguarding, medicines management, and infection prevention and control (IPC) fed into the hospital governance meetings. Information from these operational meetings, plus addition information such as patient outcomes and audit results, fed into the monthly hospital clinical governance committee meeting.

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

Heads of departments (HODs) attended the hospital's monthly clinical governance meetings and discussed how their departments were performing. They could see the key quality issues of safety, risk, clinical effectiveness and patient experience for their departments and hospital wide. HODs disseminated this information to their teams and acted on any issues arising. HODs told us they would share information with their teams in many ways including, at handovers, on notice boards and in departmental meetings. Staff confirmed this during conversations we had during our inspection.

Meetings had a set agenda which included standard agenda items such as, the risk register, infection control and audits, and other issues needing to be discussed, such as staffing levels. This showed service shared, discussed and acted upon that information within the department teams.

The service discussed governance at the medical advisory committee (MAC) and information from the MAC meetings fed into the clinical governance committee. The MAC oversaw clinical governance issues, the granting and renewing of consultants' practicing privileges, and monitored patient outcomes. The MAC had good representation of different specialities and met regularly.

The MAC's role was to ensure clinical services, procedures or interventions were provided by competent medical practitioners at the hospital. This involved reviewing consultant contracts, maintaining safe practising standards and granting practicing privileges. The MAC would also discuss new procedures to be undertaken to ensure they were safe; equipment was available, and staff had relevant training. The MAC minutes showed discussions including key governance issues, such as incidents, complaints and practising privileges had been discussed.

Good

Surgery

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

Management of risk, issues and performance

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

There were clear and effective processes for identifying, recording, managing and mitigating risks. Circle Health Group had a risk management policy which the hospital followed. This policy detailed the aim of risk management, explained what risk was and how to identify, record, review and mitigate risk.

The hospital and service maintained a risk register, that documented the type of risk, location, risk rating, description and controls in place. Named owners were assigned to individual risks and dates were included to track progress against actions. The hospital governance and clinical governance committee met monthly to discuss the risk register and update the action plan.

We found risks listed on the hospitals risk register were realistic, relevant and understood by staff. In general, staff we spoke with were able to identify risks in their service and what actions were being taken to minimise the risk. The main risks identified related to staffing, primarily in conjunction with national shortages due to the COVID-19 pandemic. Mitigations included enhancing relationships with agencies to secure regular staff to fill shifts.

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

There was a systematic corporate programme of clinical and internal audit to monitor quality, operational and financial processes in BMI hospitals. The service discussed audit findings in the clinical governance committee meetings. Clinical auditing took place to an agreed schedule. Additionally, the hospital recorded departmental health and safety checks, so any non-clinical risks were controlled.

Information Management

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

The hospital had systems to capture and manage data to drive and improve quality performance. For example, the electronic reporting system meant the hospital could capture risks and monitor themes and trends. The hospital had clear service performance measures, which the hospital, Circle Health Group and the local commissioners reported and monitored. Data collection was detailed and included data on a range of performance measures and quality indicators, such as audit results and patient feedback.

The system allowed the hospital to benchmark their outcomes against other comparable services both internally and externally.

Good

Surgery

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

Staff also told us they could access the e-learning modules required for mandatory training on their IT systems.

The hospital stored patient information and records securely in all areas we visited. Staff received information governance awareness training and followed a policy to keep patient information safe and secure.

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

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

Engagement

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

The hospital and service worked with local NHS trusts to meet the needs of the local population. This was evidenced through the way the hospital had supported the local NHS trust and cancer services during the pandemic.

The service actively encouraged patients to complete a provider feedback questionnaire about their experience. Staff asked patients to complete reviews on search engine websites.

The hospital had a presence on social media which included an informative website for people wanting to find out about the hospital and the services that it offered. The importance of this website was demonstrated during the COVID-19 pandemic keeping the public up to date when some services had needed to close or change due to government restrictions.

The hospital collated the results on a monthly basis and ranked patient response rates and rating within categories against all BMI hospitals. The hospital reviewed results at the clinical governance meetings and MAC meetings. The hospital also discussed patient satisfaction at the head of departmental meetings.

Staff were able to give feedback through an annual staff survey. There was evidence of an action plan directly derived from the results of the staff survey. For example, the hospital had already strengthened communication channels with staff and a review of staff reward and recognition had occurred. Staff we spoke with in the surgery service could tell us of changes that had occurred due to the staff survey results. Staff were aware of the actions taken in response to their feedback and were optimistic about improvements being made.

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

Good

Surgery

Learning, continuous improvement and innovation

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

The hospital was committed to improve the quality of services offered to patients. There was a focus on continuous learning and improvement. The theatre team offered apprenticeships and training opportunities which helped to develop the skills and offered career progression to individuals in the team. In addition, it meant the service could grow their own talent which helped with staff retention.

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

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

The hospital was promoting a culture of patient safety. The Circle operating system (COS) had been launched at the hospital in March 2021. Staff in the surgery service said tools had been introduced such as 'Stop the Line' and 'SWARM'.

Stop the Line empowered anyone who encountered a situation that might have caused harm to a patient or other damage to immediately make a report to the person in charge requesting that the activity is ceased.

SWARM was used to problem solve at the time and place of an issue by the people who were affected. Although these new tools were not yet fully embedded staff told us how Stop the Line and SWARM had been used. They could describe how it was an effective way of resolving an issue as it happened, as a team, to create and maintain a strong safety culture.