Ramsay Health Care UK Operations Limited

Duchy Hospital

Inspection report

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

Ratings

Overall rating for this location	Good
Are services safe?	Requires Improvement
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

We carried out this unannounced comprehensive inspection on 10 and 11 May 2022.

Ramsay Duchy Hospital is an independent hospital that provides, care to patients in the South West of England.

The hospital has a registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered person. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service is registered to provide the following regulated activities:

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

The hospital was last inspected 11, 12 and 14 October 2016 and was rated as requires improvement overall with requires improvement in Safe and Well Led. We rated all key questions for diagnostic and imaging services apart from effective as defined within our methodology.

Our previous rating included a joint rating of outpatients and diagnostic and imaging screening services, we have rated them independently as part of this inspection.

We inspected and rated the following services during this inspection:

- Surgery
- Outpatients
- Diagnostic imaging and screening procedures.

Surgery services include:

Trauma and Orthopaedic surgery, Cosmetic/Plastic Surgery, General Surgery, Ophthalmology, Gynaecology, Urology, Gastroenterology, Colorectal, Cardiology, Bariatric, ENT, Dermatology

Our rating of the location improved. We rated it as good overall because:

Surgery has been rated as good overall.

Diagnostics and screening procedures have been rated as good overall.

Outpatients has been rated as good overall.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated effective, caring, responsive and well led as good. Safe was rated as required improvement. Our rating of this service improved. 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. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. • Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week. • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. • The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and

Summary of findings

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:

- Staff did not secure medicines properly. The staff reported the environment occasionally exceeding the manufacturers recommended temperatures for the storage of medicines. Records for temperature and medicines were not always complete.
- Infection control was not always effectively managed with damaged equipment and potentially hazardous articles left in clean areas. Some areas appeared cluttered.
- A staff member was observed inserting a cannula while not using the correct aseptic technique. A soiled ruck sack was found in a clinical area.

Diagnostic imaging

Good

We rated all key questions for diagnostic and imaging services apart from effective as defined within our methodology.
Our previous rating included a joint rating of outpatients and diagnostic and imaging screening services, we have rated them independently as part of this inspection.
We did not inspect the cardiac catheter labs during this inspection as this fell within the surgery core service and was not part of this inspection.
Our rating of diagnostic imaging and screening procedures improved. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff 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. However, not all staff were up to date with mandatory training.
- Staff provided good care to patients and monitored their pain. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of

Summary of findings

patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for a diagnostic procedure.
- 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.

Outpatients

Good

The outpatient's department had a total number of 42,747 appointment visits during the period May 2021 to April 2022 of which 13,816 were NHS appointments. The service treated adults and did not treat children. The service carried out a range of consultant led outpatient services which included dermatology, cosmetic surgery, gynaecology, orthopaedics, ophthalmology and general surgery.
This was the first inspection of outpatients as a stand alone service. 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. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. Managers monitored the effectiveness of the service and

Summary of findings

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. Services were available six days a week.

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and waiting times for treatment were reasonable.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The service was behind in its cubicle curtain changing schedule and some curtains had not been changed within a six month period.
- The service had a significant amount of ophthalmic equipment stored in one consulting room which was a health and safety trip hazard issue for patients, staff and visitors using the room. This was mitigated by staff escorting patients in and out of the room.
- Access to keys for medicines was not limited to authorised personnel.
- The temperature of medicines stored in fridges were monitored by staff. However, it was not escalated when deviations in the fridge temperatures occurred. This may have caused some of the medicines to be ineffective.

Summary of findings

- The service could not identify the number of cancelled outpatients appointments as any changes to appointments on the system such as the patient requesting another date was recorded as a cancellation. This made it difficult to check the number of cancellations that were as a result of the service's own shortfalls.
- Staff were not aware of the requirement to have a sign on the door indicating when laser treatment was occurring in the ophthalmology room.

Summary of findings

Contents

Summary of this inspection

Background to Duchy Hospital

The main service provided by this hospital was surgery for a mixture of NHS and privately funded patients. 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.

The hospital has 30 beds, 29 beds were available for use at time of inspection with 26 ensuite rooms and 12-day case beds. Facilities include, physiotherapy department, three operating theatres, a day case theatre, endoscopy room, a cardiac catheter laboratory, x ray, outpatient and diagnostic facilities with 11 consulting rooms and two treatment rooms.

During the year from 1st April 2021 to 31st March 2022, 5,112 patients received treatment of which, 2,285 were NHS patients (45%). Of the overall total, 3,392 (66%) were treated as day cases.

The hospital had no never events over the past year, but had reported seven serious incidents.

Between February 2021 and February 2022, the hospital reported it carried out the following number of procedures;

Nine ear, nose and throat procedures, 161 general surgery procedures , 12 Gastroenterology , 44 Gynecology , 128 Ophthalmology, eight Oral and Maxilla Facial , 157 Plastic Surgery , 46 Spinal, 496 Orthopedic, 83 Urology, 21 Vascular, 67 Cardiology.

How we carried out this inspection

The inspection team consisted of one inspection manager, three inspectors, two specialist advisors with expertise in surgery and diagnostic imaging and one observer.

The inspection was overseen by Catherine Campbell Head of Hospital 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.

We reviewed documents and records kept by the service. For surgery we spoke with four patients and 12 staff. For diagnostic imaging we spoke with four members of staff, of whom, two were part of the management team and six patients. We spoke to five patients and 10 members of staff in outpatients during the inspection to gain their views.

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 MUST take to improve:

Summary of this inspection

Surgery

- Care and treatment must be provided in a safe way for service users. Staff must follow provider policy in recording temperatures where medicines are stored and escalate when deviations occur. They must also record opening and destruction dates on medicines. Regulation 12(2)(g).
- Providers must meet the Code of Practice on the prevention and control of infections. Staff must ensure that infection control procedures are followed when undertaking invasive procedures and that personal possessions are placed in the locker provided. Regulation 12(3).
- The service must ensure the premises and equipment used is properly maintained. In particular, they must ensure repairs and maintenance are carried out in the shower in the male changing room. Regulation 15(1) (e)

Outpatients

- Providers must ensure the safety of their premises and the equipment within it. The service must ensure medical gases such as oxygen are checked and stored securely in line with the trusts policies and procedures. Regulation 12 (2) (d).
- Staff responsible for the management and administration of medicine must be suitably trained and competent and this should be kept under review. Staff must follow policies and procedures about managing medicines. Staff must follow provider policy and record temperatures where medicines are stored and escalate when deviations occur. Staff must ensure keys to the medicine cupboard are only accessible to authorised staff members. Reg 12 (2) (g).
- The service must ensure staff are aware of the requirement to have a sign on the door indicating when laser treatment was occurring. Regulation 12 (2) (e).

Action the service SHOULD take to improve:

Surgery

- The provider should review processes to update protocols and policies regularly.
- The service should ensure the privacy curtains in clinical examination rooms are cleaned or changed as appropriate and that it is carried out as per the providers policy.
- The service should consider improving the environment in the ophthalmology / laser eye room by removing medical equipment when not in use.

Diagnostic and screening procedures

- The service should ensure that patients are given a choice of chaperone for intimate procedures (Regulation 10(1))
- The service should ensure that all staff are up to date with mandatory face to face training (Regulation 12(1)(2)(3)).

Outpatients

- The service should consider improving the environment in the ophthalmology / laser eye room by removing medical equipment when not in use.
- The service should have a process to better identify the reasons behind cancelled appointments and whether these cancellations were service, or patient led.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

Safe	Requires Improvement
Effective	Good
Caring	Outstanding
Responsive	Good
Well-led	Good

Are Surgery safe?

Requires Improvement

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. Records showed 95% of staff had completed their training. The mandatory training was comprehensive and met the needs of patients and staff. Clinical staff completed training on recognizing and responding to patients with dementia, equality and diversity, and mental capacity, and consent.

Managers monitored mandatory training and alerted staff when they needed to update their training. Noticeboards provided information on training available.

Consultants were employed under practicing privileges. Practicing privilege is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in a private hospital or clinic. The service checked consultants had completed mandatory training at their annual review. The files that we checked confirmed consultants had received mandatory training.

Safeguarding

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Safety was promoted in recruitment practice including safety checks.

Staff received specific training on how to recognise and report abuse. The nominated lead was trained to level three and had received further training from the local authority. The local lead had access to a level four safeguarding lead trained in the Ramsay group, they were available at all times, including out of hours. Staff gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. We reviewed their safeguarding policy which was in line with the latest legislation.

Staff received training specific for their role on how to recognise and report abuse. Most staff were up to date with safeguarding training at the time of inspection, training records for safeguarding showed 83% of staff working in theatres were up to date. Across all services, training compliance were at 96% for safeguarding level three for adults and 100% for safeguarding children. The hospital has a target of 95%. Safeguarding levels one and two for adults and children were online and compliance was 95%.Staff we spoke with knew how to

identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the ward.

Cleanliness, infection control and hygiene

The service controlled infection risk reasonably well. They 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.

Departmental cleaning audit for March 2022 showed a score of 97% compliance with national standards**.**

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

We observed a soiled backpack in the anaesthetic room and we were told that this belonged to a member of staff. A cupboard had been allocated for personal possession but this was not used. The backpack was still in the same place on the second day. This presented a risk of cross infection into a clean room.

Staff used audits to identify how well the service prevented infections. The clinical governance committee received reports from the infection prevention and control (IPC) lead and discussed IPC issues. A log was kept of healthcare associated infection and was discussed at the infection prevention and control meeting and included into the local annual infection control plan with action points.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff used masks, disposable gloves and gowns when completing scans. All staff we saw were bare below elbows for more effective handwashing. Staff wore surgical masks at all times. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

We saw IPC risk assessment documents which were completed at the pre-admission clinic appointment. We were told if risks were identified, they would be reviewed by clinical staff. We reviewed IPC practice in theatres during pre-operative, peri operative and post-operative phases, which were in line with guidance from the National Institute Clinical Excellence (NICE) guidance (CG 74) and the prevention of surgical site infections. However, we observed a member of staff inserting a cannula without wearing gloves.

Good

Surgery

Staff on the wards and in theatre decontaminated their hands in line with the World Health Organisation five moments for hand hygiene and NICE guidance (QS 61 statement 3).

Staff training records for infection control showed level one compliance at 96% and level two compliance at 94%. The hospital target was 95%.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Patients were screened preadmission for COVID-19. All staff received regular testing for COVID-19.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. The design of the environment followed national guidance such as the relevant Health Building Note guidance.

Staff carried out daily safety checks of specialist equipment however, we found three dates missing from the anaesthetic machine check book between 23 March 2022 and 11 April 2022.

The service had suitable facilities to meet the needs of patients' families.

The service had enough suitable equipment to help them safely care for patients, including those for bariatric surgery.

However, we found a staff shower in the male changing room did not have a cover on the drain, the front panel had come away and the flooring was not adhered to the wall.

Staff disposed of clinical waste safely. However, we found a sharps container did not have the date recorded when it was opened in line with national guidance for the safe management of clinical waste.

During our inspection, we were informed that one of the two autoclaves were not working, and the hospital was awaiting an engineer for repair. A clinical trolley was found to have rusted castors. However, we saw evidence the hospital had a programme to replace the rusty castors and the required parts had already been purchased. These were fitted during the inspection.

Assessing and responding to patient risk

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

Staff used a safer surgery and invasive procedure policy and protocol to ensure patients were assessed for their appropriateness for the procedure. Staff also used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff are trained in and used the National Early Warning Tool version 2 (NEWS2) tool. The hospital carried out an audit of the NEWS2 patient assessments in March 2022 and the results showed 97.8% compliance. Training records showed 95% of staff had received training in the use of NEWS2 and the care of the deteriorating patient.

Good

Surgery

There was a policy for the recognition and management of the deteriorating patient and staff spoken with were aware of the procedure to adopt when a deteriorating patient had been identified. There was a service level agreement with the local NHS trust for the transfer of a deteriorating patient. Transfers were discussed at the Medical Advisory Committee meetings and minutes were seen of the discussions.

Staff knew about and dealt with any specific risk issues. For example, we saw a resuscitation trolley had a copy of protocols and algorithms covering these areas.

Staff received training in sepsis (a severe and potential life-threatening reaction to an infection) awareness and used a sepsis identification tool to help identify patients who may have or developed sepsis.

There was a flowchart and protocol on the resuscitation trolley for staff to follow in the event of a cardiac arrest. However, the trolley in one of the theatres did not show the most recent guidance from the Resuscitation Council.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. We were told they would contact the local NHS Trust.

Staff shared key information to keep patients safe when handing over their care to others. A GP letter was sent to the patient's GP on discharge and a copy given to the patient.

Shift changes and handovers included all necessary key information to keep patients safe. The hospital held regular 'huddles' which were patient safety briefings. These included patient risks and resources allocated according to risk. We were told that each department allocated staff as emergency bleep holders with specific responsibilities to respond to emergency calls. All staff spoken with were aware of how to summon assistance.

We observed a case in theatre and witnessed the full completion of the World Health Organisation (WHO) surgical safety checklist. These were audited regularly and were found to be compliant.

Blood transfusions were available at the hospital and staff were trained in the procedure. An Audit was due to be carried out by the Ramsey Healthcare UK Transfusion lead in May 2022 and local audits to review the Blood Transfusion scenario were carried out, and reported to the Hospitals Clinical Governance Committee as showing improvement.

Psychological assessment/psychology services were available for those undergoing cosmetic surgery where concerns were identified.

Nurse staffing

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

The manager on the surgical ward explained that staffing numbers were determined by a dependency tool and operated on a basic ratio of one nurse to five patients during the day. This increased to one nurse to seven patients during night time hours, in line with the dependency tool and in accordance with national guidance.

Good

Surgery

The service had low turnover and vacancy rates, with low levels of sickness reported by managers. We were told that the service had low usage of bank and agency nurses. Bank staff were employed in response to rise in dependency levels and care complexity. Managers

requested staff familiar with the service and 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.

Surgery was performed by consultants and they led for both private and NHS patients.

We were told managers could access consultants when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

All staff spoken with said the service had a good skill mix of medical staff on each shift and this was reviewed regularly. The service always had a consultant on call and available within 30 minutes of the hospital, the RMO is resident.

As at the 31st March 2022, 109 Consultants were registered as approved under practicing privileges arrangements at Duchy Hospital

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. The hospital used an electronic record system which we were told all relevant staff have access to.

Managers carried out regular audits of patient records and these were discussed at the hospital's clinical governance meetings.

When patients transferred to a new team, there were no delays in staff accessing their records as the service used an electronic patent record system. On discharge, a summary of the medical records and prescribed aftercare was given to the patient and a copy sent to their GP.

Records were stored securely, and electronic records were password protected.

Medicines

The service used systems and processes to safely prescribe and administer medicines. However, the storage and records of medicines were not always effective.

Good

Surgery

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. We spoke with three patients who said they had been provided with enough information about their treatment and medicines.

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

We found that staff did not store and manage all medicines safely. Medicines were recorded as being stored at an incorrect temperature and this had not been addressed in accordance with the provider's medication policy.

We were told that the temperature in the areas where resuscitation medicines were kept could exceed the manufacturers recommended storage temperature and needed to be removed to the treatment room periodically. We observed signs explaining this and advising of the location of the medicines from the trolley.

The clinical governance meeting minutes from April 2022 reported that £1500 worth of medicines had to be destroyed because of a temperature fluctuation. Other medicine storage issues included five bags of water for injection in the warming cabinet had no date or time of opening being placed in warming cabinet.

The hospital employed a pharmacist and a pharmacy technician. The pharmacist provided a report to the Clinical Governance meeting.

We found that a scrub solution, used in surgery to disinfect hands, had no open date, a sharps bin was undated, and two copies of the British National Formulary (BNF), which provided information on all medicines used and their application, were found to be out of date, (Sept 2021 to March 2022). However, staff did have access to an electronic version of the BNF. In theatre one record of medicines administered and destroyed was found to have missing times.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Staff produced a GP letter giving details of treatment and medicines. This was given to the patient as well as being sent to the GP.

Incidents

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

The hospital used an electronic incident recording data base. We saw evidence of regular review of surgery incidents reported to the Medical Advisory Committee (MAC), Clinical Governance Committee, Heads of Department meetings and discussed with staff. We saw copies of incident audits that were made available to all staff.

The resuscitation lead for the hospital provided updates of lessons learnt post incident through discussion and training scenarios to all staff, including medical staff. Tabletop scenario training exercises were utilised, and a root cause analysis tool was used in the investigation of incidents.

Staff raised concerns and reported incidents and near misses in line with provider policy. Staff knew what incidents to report and how to report them. Staff met to discuss the feedback and look at improvements to patient care.

Good

Surgery

Managers shared learning about never events and incidents with their staff and across the organisation. We reviewed regional lessons learned documents that analysed a wide range of incidents that happened in other hospitals within the Ramsay group to share learning and prevent reoccurrence. The service had no never events. A never event is defined as a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.

Staff understood the duty of candour and were open and transparent and gave patients and families a full explanation if and when things went wrong, and an offer of a face-to-face meeting.

There was evidence that changes had been made as a result of feedback. An example was given by nursing staff on the ward and the resuscitation lead, of how the resuscitation policy had been changed to include a 999 call when transferring a patient with medical emergency to the local NHS trust from learning from a previous incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We were provided with a root cause analysis that had been undertaken in relation to one incident as well as minutes of governance and minutes of meeting from the MAC meetings where incidents were discussed.

Managers debriefed and supported staff after any serious incident. Nursing staff described how members of the senior management team and the hospital director attended the hospital following a patient death to support staff.

Are Surgery effective?

Good

Evidence-based care and treatment

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

Staff followed policies to plan and deliver high quality care according to best practice and national guidance. Many of the hospital's policies were developed centrally by the provider of the hospital. The service was also able to develop local policies and procedures to fit its specific needs. The policies had reference to national guidance such as those recommended by the National Institute for Health & Care Excellence. As a rule, most policies were reviewed every three years. The majority of the policies we checked were reviewed within this time period however some policies such as the Safer Surgery and Invasive Procedures policy were outside of their review date. The service had a policy which governs the management of all procedural documents and allows for an extension of the review period if appropriate. We were also told COVID-19 pandemic had meant some policy reviews had been delayed.

National safety standards for invasive procedures (NatSSIPS) were used to developed Local safety standards for invasive procedures (LocSSIPS). These were used as a foundation for the Hospitals Audit program for invasive procedures. These audits were carried out by the hospital for NHS funded patients as recommended by NHS England and NHS Improvement.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Good

Surgery

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 waiting to have surgery were not left nil by mouth for long periods. Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. We spoke with three patients who told us that they a had good supply of food and drinks.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. These were entered into the electronic notes, and staff completed nutritional screening assessments for all patients using nationally recognised tools.

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

Pain relief

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

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

Patients received pain relief soon after requesting it. We spoke with two patients who stated they were given pain relief when required. One patient gave an example of how a choice of pain relief was discussed with them by the surgeon.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

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

The service participated in relevant national clinical audits. The hospital contributed to the Private Healthcare Information Network (PHIN) audit. PHIN is an independent, government-mandated organisation which publishes performance and fee information about private consultants and hospitals.

Outcomes for patients were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve patients' outcomes.

The hospital carried out a pre-operative admission audit of patient notes in March 2022 which gave a pre-operative assessment score of 84.3%.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. We saw a suite of theatre, patient records and pre-operative audits with minutes of the clinical governance meetings and its sub committees reflecting discussions on findings. Managers used information from the audits to improve care and treatment.

Good

Surgery

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. The hospital attended the multi-agency cardiology oversight group facilitated by NHS Kernow Clinical Commissioning Group

The hospital entered data into the national Patient Reported Outcome Measures (PROMs). PROMs is a data set which assesses the quality of care delivered to NHS patients from the patients' perspective hip and knee replacements. The hospital provides data for hip and knee replacement. We saw this featured in the hospital's quality account document for 2020-2021. We were informed that the 2021-2022 quality document was in draft at the time of our inspection.

Managers shared and made sure staff understood information from the audits. Improvement was checked and monitored.

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 records that were seen showed evidence of qualifications.

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

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

Managers supported staff to develop through regular, constructive clinical supervision of their work. Staff told us they received regular supervision.

Clinical educators supported the learning and development needs of staff. Staff told us they had attended courses other than mandatory training for their job role and felt supported in meeting their training needs. Managers made sure staff received any specialist training for their role. We spoke with a lead resuscitation nurse and a nurse lead for thrombolysis. Both nurses stated that they had received specialist training for their roles.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We saw a calendar for staff meetings in the ward office. Staff told us meetings were held regularly.

Two sets of consultant's human resource notes were seen which showed evidence of competency and compliance with Practicing Privileges requirements.

A review of six sets of consultant and nursing Human Resource files evidenced training and skills and supervisory support.

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 Multi-Disciplinary Team (MDT) discussed any issues or risks identified at the pre-admission clinic and allocated the appropriate resources.

Staff held regular and effective MDT meetings to discuss patients and improve their care. We attended a daily MDT meeting for theatre and observed patients and their needs or risks being discussed. A patient gave an example of a multi-disciplinary team discussion that they were involved in regarding their discharge and that their views were listened to.

We were told that staff worked across health care disciplines and with other agencies when required to care for patients. We were told that if a patient deteriorates, they would transfer the patient to the local NHS hospital.

Staff referred patients for mental health assessments when they showed signs of mental ill health.

Seven-day services

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

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

Staff could call for support from doctors and other disciplines, 24/7 and the hospital was able to reopen its theatre out of hours should the need arise.

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. The hospital provided several health promotions leaflets and, pre- and post-operative advice was available.

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records. The hospital undertook a six-monthly whole hospital audit of consent practice. The last audit was undertaken in October 2021 and gave an overall score of 92.2% compliance against best practice in relation to record keeping.

Good

Surgery

Staff made sure patients consented to treatment based on all the information available. We spoke with patients who said that they were asked for their consent.

Staff received and kept up to date with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Records show that 90% of staff have received training in informed consent. We saw information about MCA and DoLS was clearly displayed on information boards.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the MHA 1983, MCA and the Children Acts 1989 and 2004 and they knew who to contact for advice. We spoke with staff who said the Matron was the lead on MCA and DoLS. The hospital did not treat children.

Staff could describe and knew how to access policy and get accurate advice on MCA and DoLS. The matron had the responsibility of overseeing the MCA and DoLs requirements

Managers monitored how well the service followed the MCA and made changes to practice when necessary.

Are Surgery caring?

Outstanding ☆

Compassionate care

Feedback from people who use the service, those who are close to them and stakeholders is continually positive about the way staff treat people. People think that staff go the extra mile and their care and support exceeds their expectations.

There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who use the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders.

Staff recognised and respected the totality of people's needs. They always took people's personal, cultural, social and religious needs into account, and found innovative ways to meet them. We spoke with a patient whose discharge had been delayed due to his mother who was his carer, passing away. The staff worked with the patient to identify a suitable accommodation. They informed us that the staff had kept them informed of developments and they were still awaiting a placement.

People's emotional and social needs were being as important as their physical needs.

People were always treated with dignity by all those involved in their care, treatment and support. Consideration of people's privacy and dignity was consistently embedded in everything that staff did, including awareness of any specific needs as these were recorded and communicated.

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

Good

Surgery

Staff were discreet and responsive when caring for patients. We saw staff closing doors to patients' rooms when they were having private conversations.

Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients told us that their care was very good, and staff were attentive and treated them with kindness and compassion.

Staff followed policy to keep patient care and treatment confidential. Ninety-four percent of staff had received training in information security and General Data Protection Regulation (GDPR).

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Records showed 96% of staff had received training in equality and diversity and 100% of senior managers had completed equality and diversity training.

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. Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Patients told us staff listened to them, they were regularly checked on and offered pain relief.

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.

People who used services and those close to them were active partners in their care. Staff were fully committed to working in partnership with people and making this a reality for each person.

Staff always empowered people who used the service to have a voice and to realise their potential. People's individual preferences and needs are always reflected in how care is delivered. One patient told us they were involved in discussions about pain relief before their procedure and were empowered to make decisions on what suited them best.

Staff found innovative ways to enable people to manage their own health and care when they can and to maintain independence as much as possible.

People felt really cared for and that they matter.

People valued their relationships with the staff team and felt that they often went 'the extra mile' for them when providing care and support. We were given an account of when the hospital had accommodated a patient who was homeless overnight and arranged transport and accommodation for them the next day.

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.

Good

Surgery

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

Staff spoke 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. The hospital carried out patient and families / carers surveys which it benchmarked against other hospitals in the company. We reviewed the survey results from March 2022. There were 13 submissions in March, twelve respondents rated the hospital as very good, one respondent did not rate but made positive comments. All respondents made very positive comments about the care they had received and there was an opportunity to give feedback on improvements that could be made.

Staff supported patients to make informed decisions about their care. Patients spoken with gave positive feedback about the service and that they had been involved in decision making.

Are Surgery responsive?

Good

Service delivery to meet the needs of local people.

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

Managers planned and organised services, so they met the needs of the local population. The service treated NHS patients as well as private patients. The hospital monitored waiting list times using the Rapid Actionable Insight Driving Reform (RAIDR) National Elective Care website and had a prioritisation programme based on the NHS prioritisation framework and guidance. The hospital utilised a prioritisation and Evidenced Based Intervention (EBI) assessment form to prioritise patients in most need.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. No breaches had been reported.

We saw a document from the local trust thanking the hospital for the support it had provided during the COVID-19 outbreak of the pandemic.

Facilities and premises were appropriate for the services being delivered.

The service had systems to help care for patients in need of additional support or specialist intervention. We were told patients could return to surgery should the need arise and there was emergency cover in place for out of hours and weekends. There was a service level agreement and protocols for the transfer out of the hospital of the critically ill patient to the local NHS trust.

Managers monitored and took action to minimise missed appointments. “Did not attend” appointment discussion was a standing agenda item in the Heads of Department meetings.

Good

Surgery

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.

Prior to admission patients received a leaflet explaining the BRAN, (Benefits, Risks, Alternatives and Nothing) and that they should ask this of their clinician. This was to encourage patients to understand their options with regards to treatment.

Staff supported patients living with dementia and learning disabilities by the introduction of patient passports. Staff report that this has been through close liaison with the Learning Disability Services in Cornwall.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss in line with national requirements and accessible communication standards.

The service had information leaflets available in languages spoken by the patients and local community. These could be made available if requested. Prior to the first appointment, a leaflet, 'your journey through Duchy hospital' was sent out explaining the procedure and what the patient could expect. This document contained photographs and signing illustrations to assist those patients with sensory and / or learning disabilities to understand their journey through the hospital.

The hospital also offers local preadmission services to support Cornish residents who are being admitted to other Ramsay Hospitals out of the area.

The service had information leaflets available in languages spoken by the patients and local community. The service had access to translation services for non-English speaking patients and families. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

The service was in the process of installing signage that also included Makaton symbols. Makaton is a unique language programme that uses symbols, signs and speech to enable people to communicate. We were told the signage was being implemented the weekend following the inspection.

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

Staff had access to communication aids to help patients become partners in their care and treatment. The hospital was in the process of installing Makaton signage across the hospital.

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. The hospital used the 999 service in an emergency.

Managers and staff worked to make sure patients did not stay longer than they needed to. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Staff supported patients when they were referred or transferred between services. We met with a patient whose discharge had been delayed while the hospital and the patient's social worker identified an appropriate placement.

Staff did not move patients between wards at night. Managers and staff worked to make sure they started discharge planning as early as possible.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. The staff and patients we spoke with knew how to raise complaints and concerns. Staff understood the policy on complaints and knew how to handle them.

The service clearly displayed on noticeboards in patient areas, information about how to raise a concern.

Managers investigated complaints and identified themes. Complaints were analysed quarterly. We saw an analysis of results between October and December 2021, which recorded 10 complaints and broke these down into five themes. The trend analysis was discussed at the quarterly clinical governance meeting and disseminated through to staff via their heads of department.

We were provided with documentary evidence of recent complaint investigations and correspondence to the complainant of the outcome and we saw Duty of Candour had been applied.

Private patients who weren't satisfied with the way in which their complaint was dealt with were signposted to the Independent Sector Complaints Adjudication Service (ISCAS). ISCAS provides independent adjudication on complaints about ISCAS subscribers. ISCAS is a voluntary subscriber scheme for the vast majority of independent healthcare providers. If a NHS patient was not satisfied with the hospitals internal process the hospitals complaints policy states that they would be able to refer the matter to the Parliamentary and Health Service Ombudsman to consider their case.

The service clearly displayed information about how to raise a concern in patient areas. The organisations 'concerns and complaints' leaflets were available in reception. Patients told us should they need to raise any concerns or a complaint they would start by speaking to the staff.

Staff understood the policy on complaints and knew how to handle them.

The service had a complaints and concerns policy stating the roles, responsibilities and processes for managing complaints. The registered manager was responsible for dealing with all complaints. We reviewed complaint tracking to confirm that patient complaints were initially responded to within two days by telephone or email depending on their preference.

Patient feedback was closely monitored and highlighted to the registered manager by administration staff. The unit had few complaints and a high level of patient satisfaction. Managers offered patients a face to face meeting to discuss their complaint.

Good

Surgery

Are Surgery well-led?

Good

Leadership

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

Leaders had the skills, knowledge, experience and integrity to run the service. Leaders understood the challenges to quality and sustainability and could identify the actions needed to address them.

Staff told us leaders were visible and approachable. There were clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and a leadership strategy and development programme, which included succession planning. We spoke with all grades of staff who stated that they had undertaken training and refresher training for their roles.

Staff told us that senior staff, including the Registered Manager, had attended the service out of hours following a serious incident to support staff.

There was clear and visible leadership at the hospital with all staff spoken with reporting that senior staff were approachable and there were no barriers to communication.

Vision and Strategy

The surgical 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.

There was a clear vision and a set of values including quality and sustainability. There was a realistic strategy for achieving the priorities and delivering good quality sustainable care. The vision, values and strategy had been developed using a structured planning process in collaboration with staff, people who used services, and external partners. Staff knew and understood what the vision, values and strategy were, and their role in achieving them. The Hospital Director told us that the Corporate values are being reviewed and further developed by the company and there is currently a consultation with staff to add further values. This consultation is reported as involving the whole company, with staff being able to contribute to the forums anonymously.

We were shown the company's value statement, and this was evident on notice boards around the hospital. Staff we spoke with were aware of the hospital values.

Culture

Good

Surgery

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 were positive and proud to work in the organisation. The culture was centred on the needs and experience of people who used services. Actions taken to address behaviour and performance was consistent with the vison and values, regardless of seniority.

There were mechanisms for providing all staff at every level with the development they needed, including high-quality appraisal and career development conversations. There was a strong emphasis on the safety and well-being of staff. Equality and diversity were promoted within and beyond the organisation. Staff, including those with protected characteristics under the Equality Act 2010, felt they were treated equitably. We spoke with staff who stated they had been supported by the hospital to undergo further training to develop in their role and interests. All staff spoken with confirmed that they received regular supervision and there were a number of committees which they could join to be involved in the running of the service.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution, and appropriate learning and action taken because of concerns raised. The provider did not have a freedom to speak up guardian, but they had a similar scheme where staff could raise concerns. The culture encouraged openness and honesty at all levels within the organisation, including people who used services, in response to incidents. Staff we spoke with understood the importance of raising concerns and felt that they would be listened to by the hospital's senior management. Staff received training in duty of candour and understood the importance of being honest when things did not go as planned. The hospital has adopted Speaking Up for Safety (SUFS) which is described as 'an organisation-wide programme, validated by the Cognitive Institute, to build a culture of safety by empowering staff to support each other and raise concerns.

Patients understood how to make a complaint and had no concerns or anxieties about making a complaint should they need to. The hospital did not have a local freedom to speak up representative however we were told the company did have a representative.

There were cooperative, supportive and appreciative relationships among staff. Teams and staff worked collaboratively, shared responsibility and resolved conflicts quickly and constructively. The service had an embedded method of raising concerns and staff told us they felt comfortable in doing this. Staff and managers spoke passionately about the service, about patient care and how they felt valued by team and wider management. Most staff we spoke with had been employed at the hospital for several years. Staff retention was reported as very good.

We were shown an award certificate of recognition presented by a local university pre-registration nursing and midwifery students to the inpatient team in recognition for outstanding contribution to practice learning. Students had also nominated the surgical theatres for placement of the year awarded by another University.

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.

Good

Surgery

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services.

The Clinical Governance team, and the Medical Advisory Committee was supported by a number of subcommittees, which included Health and Safety, Heads of Department, Information Governance, Clinical Heads of Department, Medical Devices Committee and an Infection Prevention and Control Committee. The surgery team was represented on these committees. Minutes of meetings confirmed these subcommittees reviewed audits, incidents, root cause analysis, patient outcomes, changes in national guidance and provided input into the hospital developmental plans.

All levels of governance and management functioned effectively and interacted with each other. Staff at all levels were clear about their roles and understood what they were accountable for, and to whom. Arrangements with partners and third-party providers were governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care.

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. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The organisation had assurance systems and performance issues were escalated through clear structures and processes. There were processes to manage current and future performance which were reviewed and improved through a programme of clinical and internal audit. Leaders monitored quality, operational and financial processes and had systems to identify where action should be taken. Reports demonstrated action was taken when required and improvements monitored.

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. There was alignment between recorded risks and what staff said was 'on their worry list'. Potential risks were considered when planning services, for example, seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. Impact on quality and sustainability was assessed and monitored. There were no examples of where financial pressures had compromised care.

We saw the hospitals risk register and a comprehensive business continuity plan which identified threats to surgery services and how these would be mitigated. The hospital also utilised a risk assessment log for each department. The surgery log detailed risks, impact and controls in place for identified risks.

We spoke with the Registered Manager and the Deputy Chairperson of the Medical Advisory Committee. Both demonstrated knowledge of the governance of the hospital and how the hospital's governance structures mitigated risk.

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.

Good

Surgery

Private Healthcare Information Network (PHIN) data was collected on, volume and length of stay, patient feedback, hospital reported adverse events, consultant self-pay fees, consultant reference, infections, health improvements and never events and was submitted by the hospital through the PHIN Hospital and Consultation Portal. PHIN Data for the period Oct 2020 to September 2021 showed that there had been a mean average of 396 Discharges, 50 adverse incidents, patient satisfaction was recorded as 96% and for patient experience 80%.

We were informed by managers that this information was used to measure improvement, not just assurance. Quality and sustainability both received coverage in relevant meetings at all levels.

Staff had sufficient access to information and challenged it when necessary. There were clear service performance measures which were reported and monitored by the Matron. There were effective arrangements to ensure the information used to monitor, manage and report on quality and performance was accurate. When issues were identified, information technology systems were used effectively to monitor and improve the quality of care.

There were arrangements to ensure data or notifications were submitted to external bodies as required. There were also arrangements (including internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards. Lessons were learned when there were data security breaches.

The minutes of the information Governance committee meeting in April 2022, showed discussion regarding the transfer of information to the neighbouring NHS trust and actions taken in response to an information breach. Mandatory training records showed 94% of staff had received training in information security.

Engagement

Leaders and staff engage 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.

People's views and experiences were gathered through patient and relative satisfaction surveys and acted on, to shape and improve the services and culture. This included people in a range of equality groups, people who used services, and those close to them. Staff were also actively engaged, including those with a protected characteristic, so their views were reflected in the planning and delivery of services and in shaping the culture through staff meetings.

There were positive and collaborative relationships with external partners, such as a neighbouring NHS trust, to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. There was transparency and openness with all stakeholders about performance.

We were shown evidence of hospital staff providing training for an outside organisation on blood issues and the hospital had links with two universities for the placement of students.

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.

Good

Surgery

Leaders and staff aspired to continuous learning, improvement and innovation. This included participation in appropriate research projects and recognised accreditation schemes.

There were standardised improvement tools and methods, and staff had the skills to use them. Learning from internal and external reviews was effective and included those related to mortality or death of a person using the service.

Staff regularly took time out to work together to resolve problems and to review individual and team objectives, processes and performance which led to improvements and innovation. There were systems to support improvement and innovation work, including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work.

The hospital had an online training programme and conducted face to face training. Staff spoke positively about training opportunities that had been offered and in-house training included scenario-based training to facilitate discussion and learning. One healthcare assistant told us how they had received training to expand their role and take on more responsibility.

Good

Diagnostic imaging

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

Are Diagnostic imaging safe?

Good

We rated it as good. Please refer to the main surgery report for information on overall safety.

Mandatory training

The service provided mandatory training in key skills but not all staff had updated it. Leaders did not always make sure everyone completed it. The training offered was comprehensive and assessed to reflect evidence based practice.

Mandatory training subjects were comprehensive and met the needs of patients and staff. Mandatory training was offered but not all staff were up to date.

Records showed overall face to face training for radiology staff (total of five) was at 60% compared to hospital-wide compliance of 84%. Training compliance was affected by one member of staff being on long term sickness and unable to attend training. Face to face training compliance in other areas was 67%.

Immediate life support refresher training had not been attended by any staff, however all radiographers had received basic life support and defibrillator training which was not included in mandatory training statistics. A new radiology manager had been appointed at the time of our inspection and had developed a plan with the hospital management team to achieve 100% compliance by 29 June 2022.

Records that we requested following our inspection showed compliance with e-learning training at 85% against a target of 95%. The provider has provided additional training to achieve 95% compliance across all e-learning subjects.

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

Most staff were up to date with safeguarding training at the time of inspection, with 75% having completed adult safeguarding training to level three and level two for children, in line with intercollegiate guidance document. Since our inspection, we have been provided with evidence to confirm safeguarding training compliance increased to 96% across all levels.

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

We saw staff cleaning equipment before and after patient use and used labels to show when it was last cleaned.

Hand hygiene audit results for April 2022 showed 100% staff compliance.

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 department was adapted to enable disabled patients access without any concern. Communal areas were free of clutter. The resuscitation trolley was easily accessible to staff and daily checks of the equipment had been completed.

Staff carried out daily safety checks of specialist equipment. Staff told us how equipment was maintained and included a clear handover process following servicing and repairs. The service had an equipment replacement programme for old equipment.

Scanning equipment was clearly labelled in line with the Medicines and Healthcare Products Regulatory Agency (MHRA) recommendations. Lead aprons and other equipment were formally checked annually, staff completed safety checks before each use

The service had suitable facilities to meet the needs of patients' families. Family were able to accompany patients with additional needs such as a learning disability, to make them feel more comfortable.

The service had enough suitable equipment to help them to safely care for patients. Following the inspection, we reviewed risk assessments which showed how the service monitored patients and staff for potential risk of radiation exposure. There were signs in scanning rooms and outside of scanning room doors to highlight radiation exposure to keep people safe.

Staff wore radiation monitors to ensure that they were not over-exposed to radiation and disposed of clinical waste safely. Consultants working under practicing privileges used a separate radiation detection device for each site wore two monitors to measure radiation exposure. Were completed every two months by Public Health England (PHE) to monitor staff radiation levels.

Good

Diagnostic imaging

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 reviewed the referral for each patient on arrival and confirmed the information before completing the relevant scan. We observed staff doing several identification checks including compliance with pause and check procedure and patient safety checklist to ensure that the correct scan was completed.

The service reviewed each referral and returned them if they were not appropriate. Radiology managers rejected referrals if they were not made by GPs or other clinical professionals.

The service had a clear process for managing medical emergencies whilst in the magnetic resonance imaging (MRI) mobile scanner. We reviewed the service's policy for transfer of an unwell patient to the local NHS hospital which was less than a mile away from this provider.

Staff shared key information to keep patients safe when handing over their care to other clinicians. The referral process included information such as pregnancy, to maintain safety and prevent radiation exposure. Managers told us they shared results with the local NHS trust and GPs to ensure continuity of care and prevent unnecessary duplicate scans.

The service monitored waiting times and adapted their opening hours to meet patient needs. Managers told us there was a plan to review opening times to increase accessibility for patients.

The service had an on-site radiation protection and had support from a radiation protection advisor at the nearby NHS hospital to provide oversight and assurance of compliance with radiation regulations.

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 radiographers to keep patients safe. The number of radiographers for all shifts matched the planned numbers. Managers accurately calculated and reviewed the number of radiographers needed for each shift in accordance with national Royal College of Radiologists (RCR) guidance. They adjusted staffing levels daily according to the needs of patients by reviewing appointment lists. Managers arranged for bank or agency staff to provide cover when there was absence of substantive staff. They requested bank and agency staff who were familiar with the service whenever possible. Managers made sure all bank and agency staff had a full induction and understood the service. The service was fully staffed and did not have any vacancies.

Please refer to the surgery report for information relating to this.

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

Diagnostic imaging

Staff used a hospital-wide computer system which was password protected. Scan results were returned to the referring clinician through an established and secure electronic method. Patient notes were comprehensive and all staff could access them easily. We checked four patient records which included details such as patient mental health needs in addition to any medical conditions or mobility concerns.

We observed clear handover between hospital ward and radiography staff before a scan was undertaken. Staff told us about ad-hoc patient-focused conversations with managers and consultants to provide the most effective patient care and reduce hospital admission.

Records were stored securely on an electronic computer system which was accessible by all staff. Scan results were available to NHS hospital clinicians to ensure effective continuity of care.

The service monitored records generated by staff who worked under practising privileges. These were entered onto the electronic system and made available to all relevant staff.

Staff used referral information to check for any patient risks such as pregnancy and allergies and reviewed this with the patient before the scan was completed.

Medicines

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

Staff followed systems and processes to complete required checks before contrast administration. We reviewed all contrast media and medicines which were in date and stored correctly. Staff told us that key locker codes were regularly changed and if a radiology member of staff stopped working for the provider.

Radiology staff completed a monthly audit of all medicines temperature checks in line with the provider's audit policy, we reviewed this audit and observed 100% compliance with this.

We saw full compliance with relevant licenses such as Ionising Radiation and Medical Exposure regulations IR(ME)R.

Incidents

The service managed patient safety incidents that they were aware of well. 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 received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and considered improvements to patient care. There was evidence that changes had been made as a result of feedback. For example, management had introduced real-time training scenarios as a result of staff feedback to promote consolidation of learning.

We saw evidence of managers who had investigated incidents thoroughly. Patients and their families were openly involved in these investigations to improve the service.

Good

Diagnostic imaging

Managers debriefed and supported staff after any serious incident.

All staff were aware of when to raise incidents in line with the service's policy. Following the inspection, radiology and hospital management have reminded staff by one-off briefings, team meetings and email to clarify the importance of raising incidents.

Please refer to the surgery report for more information relating to this.

Are Diagnostic imaging effective?

Inspected but not rated

Inspected but not rated. Please refer to the main surgery report for information on overall effectiveness.

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. All referrals followed the overarching criteria recommended by the Royal College of Radiologists (RCR) and were returned if they did not meet this criteria.

Patients' physical, mental health and social needs were assessed and met, evidenced by just below 100% scores in consecutive family and friends survey results from February, March and April 2022. Their care, treatment and support was delivered in line with legislation, standards and evidence-based guidance, including NICE and other expert professional bodies, to achieve effective outcomes.

The service completed monthly audits alongside NHS and other departments within the Ramsay group. The service liaised with ward staff to ensure that the patient had received prescribed medicines before being brought to the radiology department.

The service monitored staff radiation levels by using a radiation detection deviceto record radiation doses and completed a monthly audit. The service does not have a multi-disciplinary image optimisation team, however it has very close links with the local NHS hospital to share information and request assurance when required.

Nutrition and hydration

Staff gave patients food and drink when needed. Patients could access specialist dietary advice and support.

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

Good

Diagnostic imaging

Staff ensured that food was immediately available for patients who were unable to eat for a long period before their scan. This included anyone who had been unnecessarily delayed in the department, however this had never happened.

We reviewed a patient referral form which included elements such as dietary requirements and mobility concerns. The service planned for this by reviewing appointments a week before they were due, in addition to the day before.

Pain relief

Staff assessed and monitored patients regularly to see if they were in discomfort and arranged for pain relief to be given in a timely way. They supported those unable to communicate using suitable communication aids.

Staff did not administer pain relief to patients but ensured that any concerns were reported to relatives or other clinical staff during handover.

We saw communication tools and pain relief charts so that all patients could communicate effectively with staff. Staff were aware of how to use them and were aware of the importance of this.

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.

Staff always had access to up-to-date, accurate and comprehensive information on patient's care and treatment. All staff had access to an electronic records system (including bank and agency staff) they could all update.

The service participated in relevant national clinical audits. The service regularly reviewed the effectiveness of care and treatment through local audit and national audit with a structured audit programme. These audits included a monthly hand hygiene, an annual image quality and an annual Ionising Radiation (Medical Exposures) Regulations (IR(ME)R) audit.

The service was not accredited to the joint advisory group (JAG) on gastrointestinal tract (GI) endoscopy. However, we reviewed assessment notes that confirmed a further assessment was planned for June 2022 to allow the service to make adjustments.

Managers reviewed a monthly patient outcomes document and shared lessons learnt across the Ramsay group to improve care and treatment.

Managers shared and made sure staff understood information from the audits during team meetings and in safety huddles.

The service had a policy to ensure that data or notifications were submitted to external bodies as required such as monitoring of radiation levels.

Competent staff

Good

Diagnostic imaging

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. New staff were provided with induction training, which included a one-day corporate induction and managers gave new staff a full induction tailored to their role before they started work. A mentor was allocated to new staff and provided support with their induction programme and through their six-month probation period.

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

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

Managers made sure staff received any specialist training for their role by identifying any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us they could easily discuss training needs and development with their manager. One member of staff was being sponsored by the provider to complete management training to develop their career.

Two members of staff had undertaken either undergraduate or postgraduate training in magnetic resonance imaging and had attended further training courses to learn new skills. Managers explained if a staff member was required to submit evidence of their continuous professional development as part of their revalidation, they would be given time and support during work hours to complete this.

The service ensured relevant staff continued to maintain registration with relevant bodies. The service held records to show the professional registration for the clinicians was checked annually with the professional body. For example, radiographers were registered with the Health and Care Professions Council (HCPC).

Staff received training to deal with a patient who might be distressed for different reasons and told us how they would deal with this in a sensitive and caring manner.

Managers identified poor staff performance promptly and supported staff to improve. This included an annual performance review of clinicians under practising privileges.

Managers told us that they would report any suspended staff through the appropriate channels and communicate this to local NHS hospitals.

We reviewed six staff files; one member of staff had not received their yearly appraisal. The registered manager provided us with confirmation that this was completed immediately after our inspection, all other appraisals were completed correctly.

Multidisciplinary working

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

Good

Diagnostic imaging

All necessary staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment. Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. Staff ensured people received consistent, coordinated, person-centred care and support when they used or moved between different services such as district nurses and GP's by completing comprehensive handover by email and telephone.

All relevant teams, services and organisations were informed when people were discharged from the service. Where relevant, discharge was undertaken at an appropriate time of day and only done when any necessary ongoing care had been arranged.

Seven-day services

Key services were available to support timely patient care.

Staff could call for support from doctors and other areas of the hospital when required.

The service provided an on-call service at weekends for x-ray and theatre.

Please see surgery report for more information relating to this.

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 such as leaflets and a wide range of posters on display in reception and clinic rooms.

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

Please see surgery report for more information relating to this.

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. The service did not usually provide scans for 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 capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records.

Good

Diagnostic imaging

Staff received and kept up to date with training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Managers monitored the use of DoLS and made sure staff knew how to complete them. Referrals for patients who did not have capacity were returned to the referring clinician for referral to an alternative service. Staff could describe and knew how to access policy and get accurate advice on MCA and DoLS.

Are Diagnostic imaging caring?

Good

We rated it as good. Please refer to the main surgery report for information on overall caring.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. However, the provider did not offer patients the choice of whether they would like a chaperone or not when undertaking intimate procedures.

Staff were discreet and responsive when caring for patients. The reception area had screens that were introduced during the COVID-19 pandemic, but also ensured that patient privacy was maintained.

Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. For example, the service provided an interpreter service and halal food was available for patients.

Managers and staff told us that chaperones of the same gender as the patient were used for all intimate personal care and procedures, but the patient was not given a choice about this. We reviewed their policy which confirmed that the patient should be given a choice. We raised concern about this during the inspection and the registered manager confirmed that procedure was changed immediately to ensure the choice about a chaperone being present was offered.

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 said they were treated with care and respect and were given enough information about their treatment. We saw staff interactions were respectful and kind between each other and with patients and families.

Patients were provided with several information leaflets before their appointment. Reception area and separate waiting area had a wide range of leaflets available for patients including safeguarding, complaints and specific scan information.

Good

Diagnostic imaging

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff spoke to patients in a calm and patient manner and listened to their concerns about ongoing treatment and potential outcomes of their scan.

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 explained procedures well and told patients, results would be sent back to their GP or referring clinician.

Staff spoke with patients, families and carers in a way they could understand, using communication aids such as easy read documents when required.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Following the inspection, we reviewed friends and family survey data which demonstrated 100% patient satisfaction during February, March, and April 2022.

Staff supported patients to make advanced decisions about their care by using templates and prompts when speaking to patients.

Staff supported patients to make informed decisions about their care during the referral process. The service developed their own hospital passport for patients with a learning disability to highlight their wishes and used existing hospital passports to provide care in line with the patient's wishes.

Patients gave positive feedback about the service. We spoke to five patients who were very happy with the care and treatment that they received. They were aware of who to contact in an emergency if their condition deteriorated.

Are Diagnostic imaging responsive?

Good

We rated it as good. Please refer to the surgery report for information on overall responsiveness.

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.

Facilities and premises were appropriate for the services being delivered. The environment was very clean with plenty of comfortable seating, toilets, magazines and drinks machines available.

Good

Diagnostic imaging

We reviewed the patient appointment letter which was available in different formats and gave directions to the hospital. Upon arrival, we observed clear signs for patients to locate the correct department.

Hospital inpatients were brought directly to the diagnostic department by hospital staff for their x-ray. There were suitable waiting areas if patients had to wait but staff told us this was very rare.

The radiology service managed their staffing levels very closely and ensured continuity of appointments by making short term staffing changes when required.

Staff completed pre-appointment questions for patients upon arrival and rearranged appointments if they were unwell.

Managers monitored and took action to minimise missed appointments by telephone call to rearrange as appropriate.

The service relieved pressure on other departments by showing flexibility to facilitate quicker scans to reduce hospital admission.

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 supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. The service had adopted NHS patient passport to facilitate continuity of care throughout NHS and private sectors.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had wheelchairs available for patients with mobility issues. All doors were electronic and wide enough to facilitate wheelchair access. Managers told us that they had secured a bariatric MRI facility. Any specific access requirements such as a wheelchair were arranged during the referral process to avoid delay when the patient arrived.

Staff were very receptive to patient needs, they arranged for patients to call the department from the car park and wait for a call back from staff before direct entry to the department.

This was normal practice and would meet the needs of patients with dementia and learning disabilities or if they were running late.

Please see surgery report for more information relating to this.

Access and flow

People could access the service when they needed it and received the right care promptly. However, waiting times for scans were not in line with national standards.

Good

Diagnostic imaging

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The contract was commissioned by NHS England with varying contractual obligations. The service ensured that all scan results were reported within seven days . The exception to this was if there was a clinical indication for the scan to be booked for a specific date, such as treatment or surgery.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

The service did not have any cancelled appointments from May 2021 to the date of our inspection. Managers told us that they would look to rearrange any cancelled appointments as soon as possible if this happened.

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.

Please refer to the surgery report for information relating to this.

Are Diagnostic imaging well-led?

Good

We rated it as good. Please refer to the main surgery report for overall information on this.

Leadership

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

Leaders understood their local challenges and could identify the actions needed to address them. Managers at different levels told us about items on their risk register and discussed contingency plans in detail.

Staff told us leaders were visible and approachable. Staff spoke of the ability to raise concerns at all levels and felt comfortable to do this. Staff were aware of the provider's whistleblowing policy but did not feel that this was necessary due to the open and honest leadership within the service at all levels.

Staff were offered several health and wellbeing incentives by the service, including cycle to work scheme and emotional support by telephone and mobile telephone application.

There were clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and a leadership strategy and development programme, which included succession planning.

Staff told us about being supported to develop through additional training to develop their careers.

Good

Diagnostic imaging

We reviewed radiology and wider team meetings which demonstrated the provider's aspiration to develop and improve their service.

Please refer to the surgery report for information relating to this.

Vision and Strategy

The diagnostic imaging 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.

There was a clear vision and a set of values including quality and sustainability. There was a realistic strategy for achieving the priorities and delivering good quality sustainable care.

Staff told us about a programme to maintain and replace high cost equipment through capital replacement.

The vision, values and strategy had been developed using a structured planning process in collaboration with staff, people who used services, and external partners. We reviewed management meeting notes and associated action plans which showed how the service measured and made adjustments against strategic goals.

Staff knew and understood what the vision, values and strategy were, and their role in achieving them.

There was a strategy aligned to local plans in the wider health and social care economy, and services had been planned to meet the needs of the relevant population. Progress against delivery of the strategy and local plans was monitored and reviewed. The service had a good working relationship with local NHS hospital and were working to increase diagnostic scans to meet the needs of the local population.

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 felt supported, respected and valued. They were positive and proud to work in the organisation. Many staff had worked for this provider for several years and spoke of how they had been supported through long term sickness. The culture was centred on the needs and experience of people who used services.

There were mechanisms for providing all staff at every level with the development they needed. There was a strong emphasis on the safety and well-being of staff. Staff did not mention any situations of conflict but were confident that these would be resolved in an efficient and sensitive way.

Equality and diversity were promoted within and beyond the organisation in mandatory training and included in team meeting notes that we reviewed.

Good

Diagnostic imaging

There were cooperative, supportive and appreciative relationships among staff. Teams and staff worked collaboratively, shared responsibility and resolved conflicts quickly and constructively.

Governance

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

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. These were regularly reviewed and improved. Following the inspection, we reviewed governance meeting notes at a local hospital level with a clear process of how this fed into the wider organisation by staff email, staff newsletters, intranet updates and folders in staff rooms.

Governance levels at hospital management level functioned effectively and interacted with each other. Radiology staff were clear about their roles and arrangements with partners and third-party providers were governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care. The provider had service level agreements with partners such as the local NHS hospital trust. These were monitored on a yearly basis, or whenever a change was made.

We checked six employee records which showed that all staff pre-employment checks were completed correctly. The provider had an automated system for maintaining compliance with registrations such as professionals registered with the Health and Care Professionals Council. Administration staff told us that any concerns raised by governing bodies were immediately raised by electronic alert and addressed very quickly by senior managers.

We reviewed radiation protection committee meeting notes from March 2022 with other radiology units within the Ramsay group. Progress against outstanding actions was discussed with clear accountability for new actions and sharing of best practice. The service team manager worked very closely with the radiation protection advisor at the local NHS hospital to raise concerns and share information.

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. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had clear processes for escalating any performance issues through line management, appraisals, clinical and internal audit.

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. For example, the department had a risk register which fed into the hospital and was included within the corporate risk register when it was scored at an agreed level.

The provider had emergency backup generators to ensure continuity of their service. These were regularly tested. The provider also had 24/7 access to an information technology support system.

Good

Diagnostic imaging

The provider monitored patient wait times on a weekly basis and worked with local NHS trust to reduce cancer waits by undertaking cancer scans for NHS patients.

The provider held several governance meetings with clear accountability mechanism and processes to link with other groups when required.

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 service used the information it gathered to measure improvements. They completed a wide range of audits at different intervals to assess and rate their services.

The service compared their performance and used information to monitor, manage and report on quality. When issues were identified, information technology systems were used effectively to monitor and improve the quality of care by improving communication with patients through social media and their website.

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 by analysing patient feedback.

Please see surgery report for more information relating to this.

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.

Leaders and staff aspired to continuous learning, improvement and innovation. This included participation in appropriate research projects and recognised accreditation schemes such as management qualifications, Health and Care Professions Council (HCPC) and radiation safety updates. We saw audits of radiology scans which were used to identify learning. There were standardised improvement tools and methods such as the dementia strategy leaflet, and staff had the skills to use them.

Good

Outpatients

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

Are Outpatients safe?

Requires Improvement

This was the first inspection of outpatients as a stand alone service. We rated it as requires improvement. Please refer to the main surgery report for information on overall safety.

Mandatory training

The service provided mandatory training in key skills to all staff and had systems to ensure it was completed.

Staff received and kept up-to-date with their mandatory training. The service had face to face and e-learning mandatory training. Outpatients nursing and health care assistant staff had an overall compliance with face to face mandatory training of 85%. All staff had completed basic life support, hand hygiene, infection control and manual handling. We were told the pandemic had impacted face to face training and that the service was working to improve its compliance levels. Compliance with e-learning mandatory training was at 98%. Staff were prompted to complete mandatory training.

The mandatory training was mostly comprehensive and met the needs of patients and staff. However mandatory training did not currently include specific training in mental health, learning disabilities or autism. Dementia awareness training was part of mandatory training and 95% of staff had completed the e-learning course. The service did support members of staff to attend external training around learning disabilities and invited external trainers on site to deliver learning disabilities training, however it was not part of mandatory training. Mental Capacity Act 2005, Deprivation of Liberty Safeguards and consent training were covered as part of safeguarding training.

Safeguarding

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

See medical report for further information. Outpatients staff were mostly up to date with safeguarding training at the time of inspection, with 89% having completed training to level three for adults and children.

Cleanliness, infection control and hygiene

Good

Outpatients

The service controlled infection risk reasonably 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. However, the service was behind in its cubicle curtain changing schedule. Three out of the 10 consulting rooms had curtains which had been used for longer than six months albeit by less than two weeks. External good practice guidance suggests curtains should be changed every six months but this was subject to providers own risk assessment and protocols. At the time of the inspection we were informed that curtain maintenance was planned for the weekend following our inspection, the 14 and 15 May 2022. The curtains were not visibly dirty.

Staff followed infection control principles including the use of personal protective equipment (PPE). All staff were observed to be wearing PPE appropriately and were all bare below the elbow. We saw staff regularly cleaning their hands in between seeing patients. Monthly hand hygiene audits confirmed staff had good standards of hand hygiene.

The service conducted annual infection prevention control audits of the outpatients area. We reviewed the last two years audits which demonstrated that actions that arose from the previous audit were completed and that the department mostly met the set standards. Data from the past year showed there were five health care associated infections following outpatient procedures, three in orthopaedics, one in cosmetic surgery and one in dermatology. The infections were spread across the time range August 2021 to March 2022 and no trends were identified.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. The service carried out endoscopic procedures and there was a process to clean the endoscopes after each use.

The service screened patients and visitors for signs of COVID-19 at reception. Patients were asked to carry out lateral flow tests to test for COVID-19 if they were having an invasive procedure in outpatients.

Environment and equipment

The design, maintenance and use of facilities and premises mostly kept people safe. Not all equipment was safely stored. Staff were trained to use the equipment. Staff managed clinical waste well.

During the pandemic, the hospital was maintained as a 'green site', and did not treat patients with COVID-19. A one way system for patients was created to access outpatients to prevent patients mixing once they had been seen. Since the relaxation of some COVID-19 requirements, patients now entered and exited via the main reception area. We observed that chairs were spaced out in waiting areas to promote social distancing.

The design of the environment followed national guidance. All flooring was easily cleaned, and corridors were wide enough to fit wheelchairs. However, the ophthalmology / laser consultant room was cluttered with equipment and posed a trip hazard to patients and staff using the room. Following our inspection, a viability study to replace several individual items with multi-function machines to reduce the amount of equipment in the room was undertaken as well as the removal of a piece of large equipment as it was used infrequently. The risk was also mitigated by staff escorting patients in and out of the room.

The ophthalmology / laser room was locked when the laser was in use however staff were unaware that there should be a sign on the door to alert patients and staff that the laser was in use.

Staff carried out daily safety checks of specialist equipment in line with the service's policies. We saw a daily check sheet which recorded that the resuscitation trolley had been checked to ensure the equipment was available and in date. The trolley had several drawers that were sealed with tamper-evident tags.

The service had suitable facilities to meet the needs of patients' families. During the pandemic, family members were requested to not attend with the patient. However, at the time of inspection, the service was allowing family members and carers to attend outpatient appointments with patients. We were told by staff that if the waiting room became crowded, family members were requested to wait outside until the patient's appointment time.

Staff disposed of clinical waste safely. There were correct waste bins in each area which were clearly labelled with what could be disposed of in them and were regularly emptied.

Assessing and responding to patient risk

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

Patient waiting lists were managed, reviewed and risk assessed to ensure those with the greatest clinical need were seen in priority order. NHS patients were assigned a priority categorisation. The service had a strict criteria for who they could safely accept for treatment. All procedures were elective and if patients were unwell at the time of their appointment, they could be re-booked for a later date.

Staff told us they knew how to respond promptly to any sudden deterioration in a patient's health. The hospital held a daily resuscitation huddle, which was a meeting to discuss the role of each emergency team member and ensure they were familiar with protocols and policy. We were told staff would call 999 for any patient who deteriorated on its premises. Staff also had access to a medical officer who provided support to outpatient staff if a patient became unwell. The service had policies which clearly explained responsibilities should an event requiring swift action arise.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool. Staff could view patients notes which flagged whether there were any specific risk issues such as allergies or any mental health issues.

Staff would contact the community mental health team if a patient required support.

Staff shared key information to keep patients safe when handing over their care to others. They regularly shared information with the NHS about the patients they cared for and patient's GPs when this was needed.

Shift changes and handovers included all necessary key information to keep patients safe. The service had three shifts and conducted a safety huddle at 12 noon where key information was shared. The time of the safety huddle enabled all staff the opportunity to attend.

Staff had life support training and there was always a member of staff on site who had advanced life support training.

Nurse staffing

The service had 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 used bank staff to fill vacant shifts.

Good

Outpatients

The service was close to its full-time establishment for nursing staff.

The service did not use agency staff but sometimes utilised bank staff that were familiar with the service.

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

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. Medical staff led their own clinics and consultants would provide the hospital with their availability in advance of clinics being booked.

The hospital completed relevant checks against the Disclosure and Barring Service. The registered manager and Medical Advisory Committee chair liaised appropriately with the General Medical Council (GMC) and local NHS trusts to check for any concerns and restrictions on practice for individual consultants. The GMC is a public body that maintains the official register of medical practitioners within the United Kingdom

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.

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

All records were stored securely. We observed computers were locked when not in use.

Consultants added notes to the electronic system and dictated patient letters to their medical secretary whom copied these to the patient, the medical records team and the patient's GP. Patient notes and consent form were scanned and uploaded onto the system at discharge. The electronic system enabled any clinician to access notes for an appointment, enabling patients to see any specialist available. The service used the same system as the local NHS trust and consultants were able to access patient information on both systems.

Medicines

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

Staff followed most systems and processes when safely prescribing, administering, recording and storing medicines. Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We observed clinicians discussing medicines with patients and checking they understood how to obtain and take them. The service had introduced an in-house pharmacy service since the last inspection which operated Monday to Friday.

Good

Outpatients

Staff stored medicines and prescribing documents mostly in line with the provider's policy. Pharmacy checked the outpatients medicines cupboards weekly and clearly identified any that were due to expire with a red sticker. However, we observed access to the keys for the medicines cupboard was not in line with regulations as health care assistants also had access to the key cupboard. This also did not follow the services policy which stated "The responsible person in charge of the keys may only allow registered healthcare practitioners to have unsupervised access to medicines. Non-registered healthcare practitioners may only be given access once a competency assessment has been completed and signed off". This was brought to the attention of the service who installed a separate key lock cupboard the following day of inspection which only allowed access to the keys to the drug cupboard to the registered nurses. The service did not have any controlled drugs.

We saw that the service monitored the temperature of medicines that required refrigeration and medicines that were stored in cupboards by completing a daily checklist. However, we observed there was an incident where the cupboard temperature exceeded the minimum and maximum temperature and the correct procedure was not followed. The incident should have been reported to the outpatients manager who would have alerted pharmacy to review and dispose of any medicines that may have been affected by the temperature falling outside of recommended range. The outpatients manager was not alerted however, we brought this to their attention and pharmacy was contacted to review the medicines and the manager said they would share this as a learning incident to the outpatients staff team.

Most oxygen cylinders were stored safely and securely to walls. However, we found one oxygen cylinder stored on the floor of a treatment room. When we informed staff, we were told that they were waiting for the porters to take this away. When we returned to the room, we saw that the oxygen cylinder had been removed.

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 in outpatients knew what incidents to report and how to report them. All staff we spoke with were clear about their duty to report incidents and knew how to do so using the electronic reporting system.

Staff raised concerns and reported incidents and near misses in line with the service's policy.

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 received feedback from the investigation of incidents.

Are Outpatients effective?

Inspected but not rated

We do not rate effective in outpatients. Please refer to the main surgery report for information on overall effective summary.

Good

Outpatients

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.

See surgery report.

Pain relief

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

Staff assessed and discussed pain with patients. Staff assessed patients' pain and medical staff could prescribe pain relief. We observed clinicians discussing patient's pain levels and pain relief in clinic.

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 a comprehensive rolling audit programme which was run nationally, however local audits were also conducted and were focused on areas to drive improvements in the service. A patients notes audit was conducted annually with the option of greater frequency if appropriate. We saw examples of leadership acting on audit results and monitoring whether any issues were new or if they had been previously identified.

Managers shared and made sure staff understood information from the audits. The service had implemented an electronic platform for recording audits which led to greater engagement with staff and resulted in improved compliance with both audit timescales, action planning and monitoring improvement.

Competent staff

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

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

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

Managers supported staff to develop through yearly, constructive appraisals of their work. Outpatients department had the lowest level of compliance for appraisals across the service but this will still high at 92% as at 17 May 2022.

Managers encouraged staff to attend team meetings and held these at a time where the majority of staff were able to attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff were actively encouraged to develop their skills. For example health care assistants were currently undertaking scrub training so they can assist with minor procedures in the outpatients department. All staff we spoke with said the service supported their learning and development needs.

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 multidisciplinary meetings to discuss patients and improve their care. Nursing staff said they had regular meetings with physiotherapists about patients and their onward care plans. The service did not treat patients with cancer.

Patients could see all the health professionals involved in their care at one-stop clinics. Orthopaedic clinics were supported by diagnostic and imaging staff and all staff reported good multidisciplinary working with the physiotherapists. Staff worked across health care disciplines and with other agencies when required to care for patients. Staff were able to speak with patient's GPs if they needed to clarify anything about their care.

Seven-day services

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

Clinics were open Monday to Friday from 8am to 8pm and on Saturday from 8am to 4pm.

Health promotion

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

The service provided health information to patients at the pre-assessment clinics. We observed one consultation where the consultant provided the patient options which included advice on managing their illness using diet.

The service included the requirement to offer health advice on smoking, vaping, obesity, diet, alcohol consumption in its policies. The service had information leaflets on these subjects which were given to patients.

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 capacity to make decisions about their care. The majority of clinics were consultant led so the patient's consultant was always available to assess a patient's capacity to consent for treatment. Nursing staff were running blood clinics, however all staff described to us when they might be concerned about a patient's capacity and how they would raise this with consultants or with the matron or refer to the community mental health team.

Good

Outpatients

Staff could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards. Policies were stored electronically and were readily accessible to all staff.

The hospital had a policy outlining the principles of consenting patients and of capacity to consent.

We audited five records and saw evidence of consent was gained in all five records.

The service audited their consent forms twice a year and found that consent was gained in line with processes.

Are Outpatients caring?

Good

This was the first inspection of outpatients as a stand alone service. We rated it as good. Please refer to the main surgery report for information on overall caring.

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 being friendly and kind to all patients.

Staff knew their patients well and ensured they interacted with patients in a way that made them feel that they were being cared for as a person and not just their diagnosis being treated.

Patients said staff treated them well and with kindness. Patients we spoke with talked of how kind and considerate all staff members had been. The service scored highly on patient surveys regarding respect and dignity and patient experience. The service was also performing above the average of the other services in the group in terms of patient feedback. Friends and family feedback was positive however it should be noted that there were 13 respondents.

Staff followed policy to keep patient care and treatment confidential.

Patients were able to request a chaperone. There were posters on the waiting room walls promoting this service as well as in consulting rooms. Staff told us there was never any difficulty in obtaining a chaperone for patients who requested this.

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.

Good

Outpatients

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We were told about an incident with a patient living with autism where staff gave the patient a separate room in order to provide a calmer environment for them to wait prior to their appointment.

We observed consultants giving diagnosis and allowing the patient time to digest the information prior to discussing the various treatment paths.

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

Understanding and involvement of patients and those close to them

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

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

Receptionists worked with patients to ensure they understood the appointment sequence and other aspects of their visit, such as waiting times. We saw nurses talking to patients in the waiting room to check on their welfare and how long they had been waiting.

Staff told us that during the pandemic, arrangements were made for family members to attend appointments if the patient required support.

Staff spoke with patients, families and carers in a way they could understand.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There were leaflets on how to make a complaint in the reception area and a box where patients could post any feedback.

Staff supported patients to make informed decisions about their care. We observed care where patients were given all possible treatment options with an explanation as to the degree of pain associated with each procedure as well as options that required minimal treatment such as a change in diet.

Patients gave positive feedback about the service.

Are Outpatients responsive?

Good

We rated it as good. This was the first inspection of outpatients as a stand alone service. We rated it as good. Please refer to the main surgery report for information on overall responsive.

Service delivery to meet the needs of local people

Good

Outpatients

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

Managers planned and organised services so they met the needs of the local population. Outpatient clinics were arranged in line with the demand for each speciality. If consulting space was available, consultants could arrange ad hoc appointments to meet patient needs. The service was open on Saturdays however, there were generally less consultants available to run clinics on this day and consequently less patients were seen on a Saturday.

Patients could access treatment at the hospital in a number of ways. Private/self-pay/insured patients could self-refer. NHS patients were referred via their GP into a referral management service or via a clinical assessment service.

The service tried to minimise the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. For example, diagnostic imaging was available on the same day as the orthopaedic clinic. We observed patients who had more than one outpatient appointment on the same day. Whilst there was sometimes a waiting time between appointments, due to the distance and the service being the only private hospital in the county, we were told patients would prefer this rather than attending on different days.

Facilities and premises were appropriate for the services being delivered. The service provided free parking for patients and visitors and there were parking spaces for patients with mobility difficulties.

Staff would contact the community mental health team if a patient experienced mental health difficulties. Managers ensured that patients who did not attend appointments were contacted.

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Patients who had mental health problems, learning disabilities and dementia could attend appointments with a carer. The service had dementia champions for staff to access if required. Staff told us they treated and supported patients with additional needs and during the COVID-19 pandemic had always allowed these patients to have a relative or carer to support them, while other patients were asked to attend alone.

There was an induction loop at the outpatient reception area to assist patients with hearing difficulties. The outpatient toilet was accessible for disabled people and also provided an audio description of the room for blind or partially sighted people.

The service was in the process of installing signage that also included Makaton symbols. Please see surgery report.

Signs offering patients a chaperone were clearly displayed in waiting areas and clinical rooms.

The waiting room gave patients and their family or carers free access to tea, coffee and water. Most patients seen in the outpatient department did not need food as the appointments were very quick.

NHS and private patients attending the service received good continuity of care. Patients saw the same consultant for consultations, clinics and follow up appointments. The service allowed a longer time period for initial consultation than follow up appointments.

Good

Outpatients

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 better than the national standard of 18 weeks.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Waiting times for outpatients appointments were in the main less than four weeks, with only dermatology which had a waiting time of nine weeks, but was within the 18 week Referral to Treatment target set for NHS patients. The service treated NHS patients and private patients.

Managers worked to keep the number of cancelled appointments and treatments to a minimum.

When patients had their appointments and treatments cancelled at the last minute, managers made sure they were rearranged as soon as possible.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. There were leaflets in the reception area which gave information on how to raise a complaint. The providers website had a patient feedback option which was easy to navigate.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. Managers looked at the complaints received and the themes identified from these complaints each quarter. There was evidence of learning from complaints with the service making improvements to improve its daily practice.

Staff knew how to acknowledge complaints and patients received feedback from the hospital director after the investigation into their complaint.

Are Outpatients well-led?

Good

This was the first inspection of outpatients as a stand alone service. We rated it as good. Please refer to the main surgery report for information on overall leadership.

Leadership

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

There were clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and a leadership strategy and development programme, which included succession planning.

The outpatient manager had been in role since January 2022 and was aware of the importance of building a team that worked well together. From conversations with staff, it was clear that they all enjoyed working together and for the service and they were supported to develop and expand their roles and encouraged to attend training.

The outpatient manager's role was to bridge the gap between the senior registered nurses and the matron. Staff we spoke with said having the manager in the new role to deal with various management issues was an improvement from having to report directly to the matron overseeing the whole service. All staff were happy to approach the outpatient manager with any issues or concerns.

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 vision, values and strategy had been developed using a structured planning process in collaboration with staff, people who used services, and external partners. Staff knew and understood what the vision, values and strategy were, and their role in achieving them. See surgery report for further information.

Staff were able to tell us about the hospital vision and values and we saw that these were put into practice daily, with staff being polite and friendly to everyone visiting the hospital. The hospital was working in partnership with the local NHS trust to ensure patients received timely care.

The outpatient manager described what their vision was for the future of the department, they wanted to look into how to expand the scope of practice for nurses and expand the footprint of the outpatients department so they could provide better care for more patients.

Culture

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

Staff told us they really enjoyed working at the hospital and in outpatients, they felt there was a "close knit team" with a "family feel". Many staff spoke of how themselves, friends and family members had chosen to be treated at the hospital.

The service had recently completed a piece of work which encouraged staff to speak out for safety. Staff we spoke with stated they were confident about raising safety related concerns and would also be confident to raise concerns regarding consultant practice. Whilst there was not a local freedom to speak up representative, there was someone identified in the organisation who carried out a similar role.

Staff were actively encouraged to undertake training and were offered opportunities for career development. We spoke to one health care assistant who was being supported in completing GCSE's in maths and English so they could further their career. Another example was a nurse who wanted experience in theatres, rather than leaving the outpatients department completely, they were offered a job share role across the two departments.

There was a strong emphasis on the safety and well-being of staff. Staff had access to employee assistance programmes which included wellbeing offers and mental health help and advice. Staff we spoke to were aware of the programme and some had used its services.

Governance

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

There were mostly effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. These were regularly reviewed and improved. All levels of governance and management functioned effectively and interacted with each other. Staff at all levels were clear about their roles and understood what they were accountable for, and to whom. Arrangements with partners and third-party providers were governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care.

A medical advisory committee (MAC) met quarterly with broad representation from specialities. The committee discussed safety and governance and included reviewing and approving consultants practicing privileges requests.

However, the service could not identify the number of cancelled outpatients appointments as any changes to appointments on the system such as, the patient requesting another date was recorded as a cancellation. This made it difficult to check the number of cancellations that were as a result of the service's own shortfalls.

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. They had plans to cope with unexpected events.

The organisation had assurance systems and performance issues were escalated through clear structures and processes. There were processes to manage current and future performance which were reviewed and improved through a programme of clinical and internal audit. Leaders monitored quality, operational and financial processes and had systems to identify where action should be taken. Reports demonstrated action was taken when required and improvements monitored.

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.

Good

Outpatients

The service used electronic systems to report incidents and to hold all their policies. The main policies from the provider were all available on the electronic system and were amended to fit the local environment using local operating procedures.

All clinical records were electronic, and the same electronic system was used by the NHS local trust so electronic records were immediately available if a patient's care was handed over to the local trust or another hospital in the wider providers group.

There were arrangements to ensure data or notifications were submitted to external bodies as required. CQC had received the relevant notifications from the service regarding notifiable incidents.

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.

People's views and experiences were gathered and acted on to shape and improve the services and culture. This included people who used services, and those close to them. Staff were also actively engaged so their views were reflected in the planning and delivery of services and in shaping the culture. The latest friends and family score for outpatients stated that 99% of patients would recommend the hospital from 2094 responses. Another website collating views of patients gave the hospital a five star review from 49 reviews.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. There was transparency and openness with all stakeholders about performance.

Duchy Hospital was a member on delivery boards working within the healthcare system to deliver integrated planned care to the population of Cornwall and the Isles of Scilly.

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.

The culture of the organisation promoted learning and improvement. All staff said they were encouraged to attend training and work on their skills to aid with career progression.