The New Foscote Hospital Limited

The New Foscote Hospital

Inspection report

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

Ratings

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

Summary of findings

Overall summary

We have not previously rated the service, although the service was inspected and rated as good in 2016, when it was under different ownership. We rated it as good because:

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

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	This service has not been rated previously. It was inspected and rated in 2016 but was then under different ownership. We rated it as good because: • The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe and to provide the right care and treatment. • Infection prevention and control processes had been reviewed and developed further to support staff practices during the pandemic. • Equipment on the wards and theatre were managed effectively with evidence of regular checks and clear records were maintained. This included the emergency equipment such as the resuscitation trolleys which were tagged and easily accessible. • The service provided mandatory training in key skills to all staff and monitored training compliance. • The service managed medicines safely and followed good practice guidance. Staff followed their procedures for access to the pharmacy out-of-hours. • Staff engaged in clinical and submitted data to national audits to evaluate the quality of care they provided. • Managers ensured staff received training, supervision and appraisal. The ward staff worked well together and as a multidisciplinary team. • Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. • Managers regularly reviewed and adjusted staffing levels and skill mix to provide care and treatment safely. • Staff understood how to protect patients from abuse and had training on how to recognise and report abuse and they knew how to apply it. • Managers used 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.

Summary of findings

- Staff were focused on the needs of patients and delivering individualised care. Staff were clear about their roles and accountabilities.
- The service engaged well with patients and the community to plan and manage services. All staff were committed to improving services continually.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in their daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders 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.
- 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.

Medical care (Including older people's care)

Good

We have not previously rated the service, although the service was inspected and rated as good in 2016, when it was under different ownership. We rated it as good because:

- The service provided training in key skills to all staff and made sure everyone completed it. Staff had training on how to recognise and report abuse and they knew how to apply it. All areas within the clinic were clean and had suitable furnishings. The design, maintenance and use of facilities, premises and equipment kept people safe. Staff completed and updated risk assessments to remove or minimise risks. The service had enough staff with the right qualifications, skills, training and experience. There was a system to report safety incidents and staff knew how to report incidents and near misses.
- 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, supported them to make decisions about their care, and had access to good information.

- Staff treated patients with compassion and kindness, respected their privacy and dignity and took account of their individual needs.
- 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 had the skills and abilities to run the service and were visible and approachable. There was a clear leadership structure from service level to senior management level. Staff were aware of the overall vision and strategy and felt part of the vision for the hospital. Staff felt respected, supported and valued. The service had an open culture where staff could raise concerns. Leaders operated effective governance processes. Leaders and teams used systems to manage performance effectively. The service collected reliable data and analysed it. The information systems were integrated and secure. Leaders and staff engaged well with colleagues. Staff were committed to continually learning and improving services.

Outpatients

Good

This service has not been rated previously. It was inspected and rated in 2016 but was then under different ownership. We rated it as good because:

- The service provided training in key skills to all staff and made sure everyone completed it. Staff had training on how to recognise and report abuse and they knew how to apply it. All areas within the departments were clean and had suitable furnishings. The design, maintenance and use of facilities, premises and equipment mostly kept people safe. The service had enough staff with the right qualifications, skills, training and experience. There was a system to report safety incidents and staff knew how to report incidents and near misses.
- Staff provided good care and treatment. Managers monitored the effectiveness of the service and

Summary of findings

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However:

- The service did not always follow best practices of Infection prevention and control.
- The service did not report all incidents appropriately on the hospital's incident management system.
- The risk register for the service contained information that was not up to date.

Summary of findings

Contents

Summary of this inspection — Page

Background to The New Foscote Hospital 8

Information about The New Foscote Hospital 9

Our findings from this inspection

Overview of ratings 11

Our findings by main service 12

Summary of this inspection

Background to The New Foscote Hospital

The New Foscote Hospital is operated by The New Foscote Hospital Limited. The hospital is based in Banbury, Oxfordshire. The hospital was first opened in 1981 and was known as The Foscote Hospital. In 2019 the hospital was bought by a family investment fund and became known as The New Foscote Hospital. Since the purchase the hospital has been undergoing a transformation process.

The New Foscote Hospital provides surgery, endoscopy, outpatients and diagnostic imaging services. The hospital provides care and treatment to adults who have private medical insurance, pay for themselves and NHS funded patients.

In the reporting period from June 2020 to May 2021:

- There were 1,767 surgery day cases and 256 inpatient episodes of care recorded at the hospital; of these 58% were privately/ insured funded patients and 42% NHS-funded.
- The endoscopy service was undertaking an average of 10 endoscopy procedures per week for patients over the age of 18 years.
- There were 10,151 outpatient total attendances; of these 64% were privately/ insured funded patients and 36% were NHS-funded.
- There were 1,007 physiotherapy attendances; of these 99% were privately/ insured funded patients and 1% were NHS-funded.
- The imaging service was undertaking an average of 24 plain film x-rays per month at the time of our visit. Ultrasound clinics were run mostly in the evenings and staff carried out approximately 120 scans per week; 80% were NHS patients and 20% were privately funded.

The hospital has 12 ensuite bedrooms, four-day case bays, one operating theatre and an endoscopy suite. There is an outpatient department with consulting and treatment rooms and a diagnostic imaging service offering plain film X-ray imaging and ultrasound. There are no emergency facilities at this hospital.

The hospital is registered to provide the following regulated activities:

- Diagnostic and Screening Procedures
- Surgical Procedures
- Family Planning
- Treatment of Disease, Disorder or Injury

The registered manager who has been in post since May 2020.

The hospital was previously inspected in 2016 when it was under different ownership and rated as good.

We inspected The New Foscote Hospital using our comprehensive inspection methodology. We first visited 8-9 January 2020 but were unable to complete the inspection process at that time. The impact of the COVID-19 pandemic created a significant delay and we returned to the New Foscote Hospital on 16 June 2021.

Summary of this inspection

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

The outpatient summary includes outpatient clinics provided by the physiotherapy team and services offered by the diagnostic imaging service, which at the time of our inspection was limited to plain film x-ray imaging and an ultrasound service.

How we carried out this inspection

During the inspection, we assessed the surgical, endoscopy and outpatients and diagnostics imaging services. We also reviewed the overall governance processes for the hospital and reported on this as part of the well-led domain. We spoke with approximately 25 members of staff and six patients, observed patient care and procedures with the consent of the patients, looked at patient waiting areas and clinical environments, attended staff huddles, looked at 15 patients' care and treatment records, and at hospital policies, procedures and other documents relating to the running of the services.

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.

Outstanding practice

We found the following outstanding practice:

- The provider had developed a comprehensive, personalised and progressive induction support and recording package that was based on the organisational civic responsibilities. This set clear expectations and objectives from the start of each person's employment. The process was managed by line managers, with active involvement from the director of people and culture who ensured consistency and fairness.
- The provider had introduced an in- house, two-year graduate management training programme to support staff's development and career progression.
- Agreement had been given for the hospital to offer both undergraduate nurse training and General Medical Council surgical training courses.
- All staff reported feeling proud to work at the New Foscote Hospital. 100% had said they strongly agreed with the statement that said they were proud to work at the hospital in the March 2021 staff survey.
- Staff recognised and responded to the holistic needs of their patients throughout their surgical pathways and carried checks on their wellbeing after they were discharged from the hospital.
- Leaders had invested in a diverse staff team and promoted diversity and inclusion in caring for their staff and patients.
- The provider had developed additional surgical care and procedures guidance during the pandemic. This included clear information for patient's agreement to investigation or treatment and statement of health professionals seeking consent.

Summary of this inspection

Areas for improvement

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

Action the service SHOULD take to improve:

- The provider should ensure anaphylaxis boxes are clearly labelled, and the contents updated in line with latest guidelines. (Regulation 12(1)(2)(g))
- The provider should ensure controlled drugs audits are completed and recorded. (Regulation 12(1)(2)(g))
- The provider should ensure infection, prevention and control procedures are followed regarding the storage of boxes, wipe clean equipment used in radiology and the removal of out of date consumables. (Regulations 12(1)(2)(h); 15(1)(e))
- The provider should ensure all types of incidents are reported appropriately on the hospital incident management system. (Regulation 17(1)(2)(a))
- The provider should ensure the risk register is current and up to date. (Regulation 17(1)(2)(b))
- The provider should consider developing a process to record and audit stock medicines.
- The provider should consider making sure ward meetings are occurring and they follow a set agenda to ensure all staff are receiving information on key quality issues of, safety, risk, clinical effectiveness and patient experience in a formal minuted way.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are Surgery safe?

Good

Safe had not been rated previously. It was inspected and rated in 2016 but was then under different ownership. We rated it as good.

Mandatory training

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

The mandatory training schedule was monitored which staff said they completed when they joined the service and was relevant to their roles. The directors of nursing for inpatient wards and theatres were responsible for monitoring compliance and reminded staff when they were due a refresher course. Mandatory training data showed staff were 100% compliant with training requirements as set by the hospital.

Staff had completed training in modules including but not limited to, basic life support and advanced life support, health and safety, infection control including refresher training for COVID -19 management. Other mandatory training was fire safety and moving and handling. Fire safety training was outsourced and included fire warden training for the designated staff.

Clinical staff had completed training in sepsis recognition and management. The provider monitored training compliance and 77% of staff had completed sepsis training. Ongoing training was planned, and the shortfall was due to new staff who had recently joined the service.

Medical staff received and kept up-to-date with their mandatory training. The service had doctors and anaesthetists who worked under a service level agreement (SLA). They were required to provide evidence from their current NHS role of their compliance with mandatory training as part of their SLA. This information was checked and recorded in the individual staff's file and we were assured that this was up-to-date in the records we reviewed during the inspection.

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

Surgery

The service had effective systems and processes to follow and supported the staff in raising safeguarding concerns. Safeguarding referral forms were available, and staff knew how to access and use them.

Staff could give examples of what constituted as abuse and how to raise any concerns. They knew how to protect patients from poor care and discrimination, including those with protected characteristics under the Equality Act 2010.

The director of nursing was the lead for safeguarding and had oversight of any referrals made in order to support staff and patients. The provider had corporate safeguarding adults and children policies that reflected the current national guidance.

The safeguarding policy considered their recruitment practice to protect patients from the risks of abuse. There were clear arrangements to support staff ensuring they had an up to date enhanced Disclosure and Barring Service (DBS) checks prior to them starting work.

Staff including senior managers were supported to undertake regular updates in safeguarding to maintain their skills and followed procedures aimed at safeguarding children and adults. Training records showed all staff trained to level 2 and senior staff trained to level 3. Data showed that staff had achieved 100% compliance with safeguarding training.

Safeguarding was discussed at head of department meetings as well as the governance meetings to ensure that there was learning from any incident and information shared. The service had not made any safeguarding referrals in the last 12 months.

The service had a rolling training programme for PREVENT/WRAP and the current raining compliance was 79%. The provider was monitoring the training data and told us the previous rate of 90% plus was reduced due to the number of new starters and team expansion. PREVENT raises awareness to stop individuals from getting involved, supporting terrorism or extremist activity. PREVENT is the duty in the Counter-Terrorism and Security Act 2015 by which staff in health care settings must have training to identify ways to prevent people from being drawn into terrorism or extremist activity.

Cleanliness, infection control and hygiene

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

Staff had access to a variety of resources for the infection prevention and control (IPC) which included hand washing, personal protective equipment (PPE), keeping a safe distance and risk assessments. Signages were clear and in pictorial formats which included face covering and public transport, keeping a safe distance, staying alert and staying alert to risk of infection and washing hands for at least 20 seconds.

The registered manager had contacted Public Health England (PHE) at the height of the pandemic and developed their guidance from the information received for the management of COVID-19.

This included guidance on elective surgery such as home isolation and a negative COVID-19 test prior to surgery. Patients had a lateral flow test on arrival and prior to admission to the ward. All staff had twice weekly lateral flow tests completed.

Good

Surgery

Staff followed their infection control procedures as patients were all accommodated in single rooms and staff told us this enhanced their ability to isolate patients if suspected of having an infectious condition. At the time of the inspection, the management had taken a decision to stop visitors to minimise the risks of infection.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff followed infection prevention and control guidelines such as bare below the elbow in clinical areas. Staff adhered to the five moments of hand washing in line with the World Health Organisation (WHO) protocols to prevent the spread of infection. The service carried out monthly hand washing audits and cleaning audits to monitor adherence to infection control practices. The latest audit results showed 100% compliance.

The service had reviewed their hand washing facilities during the pandemic and had put in place extra sinks in the corridor outside the patients' rooms to enhance infection prevention and control practices. PPE were available outside patients' rooms which included gloves, aprons and masks. Staff followed good infection control procedures by donning and doffing PPE and washing their hands regularly and disposing of PPE in the appropriate bins.

There had been no cases of healthcare-associated infection Methicillin-resistant Staphylococcus aureus (MRSA) in the last 12 months. Procedures had been developed to assess patients and they were routinely screened for MRSA as part of their pre- operative process. Staff followed their procedures including routine testing of susceptible patients in line with best practice guidelines.

Staff followed good practice guidance and maintained clean and dirty flow within operating theatre. This included limiting the number of staff entering the operating theatre during surgery and restricting the movement of personnel in the operating theatre to a minimum. There was an effective facility for the sterilisation of surgical instruments as the service had a service level agreement with a local NHS trust.

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

The policy for cleaning of re-usable non- invasive equipment guidance was reviewed in July 2020. Once an equipment had been cleaned, 'I am clean sticker' was placed on the piece of equipment to advise staff it was safe to use.

Audit looked at proportion of inpatients who underwent sepsis screening and who, where screening was positive received intravenous (IV) antibiotic treatment within one hour of diagnosis. The service had set (Operating standard of 90% based on a sample of 50 service users each Quarter) Result from audits undertaken in September and December 2020 showed they were compliant.

The service monitored their surgical site infection rates for procedures which included hip and knee arthroplasty, breast surgery and urology. The service had declared they had no surgical site infections. The service undertook an audit of antimicrobial prescriptions in December 2020 and achieved 100% compliance.

The Chief Operating Officer was responsible for ensuring that all clinical staff had completed infection control training and certification. The training included the relevant transmittable infectious diseases module.

Good

Surgery

The service had infection prevention and control measures to prevent the spread of COVID-19. All staff completed twice weekly lateral flow testing and records of these were maintained. The vaccination status of all staff was recorded in their personnel records with only two new staff members waiting to be vaccinated. Records showed a high uptake of vaccination amongst the clinical and non- clinical staff.

Prior to returning to work, employees were required to complete a "pre-return to work" form confirming that to the best of their knowledge, they had not been in potential contact with COVID-19.

A COVID-19 business response plan was drawn to address the potential level of risk (including for individual workers) and procedures were developed to respond to suspected cases. Temperature testing had been implemented at the entrance of the hospital in the reception area which was in line with public health advice. Hand gels was available at the entrance and the wards.

The hospital was well ventilated with restricted windows that could be partially opened to allow a flow of fresh air. This was supplemented by mobile air conditioning units and high-quality cooling fans. There was a service level agreement with a third party for regular water quality testing. This was supplemented by weekly run off from every water outlet to reduce the risk of legionella.

The hospital catering team had current environmental health certification and staff had completed their food hygiene training.

There was appropriate management of waste through service level agreements with third party contractors. The contracts were closely monitored and adherence to waste disposal policies was reported to the Head of Estates. During the pandemic, the clinical waste disposal contract had been increased to allow for increased use of personal protective equipment. Waste was stored in locked cages away from public access.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. There was good oversight of environmental risks and strong governance of estates and facilities.

The service had enough suitable equipment to safely care for patients. The staff had received training in the use of equipment which depended on the area that they worked. Staff carried out daily safety checks of specialist equipment including the emergency resuscitation trolleys and equipment used in the operating theatres.

We reviewed three resuscitation trolleys which were in prominent places on the ward and the operating theatre for easy access in an emergency. The resuscitation trolleys contained tamper evident tags and these were checked daily and weekly in line with their internal policy. Clear records of checks were maintained and laminated resuscitation guidelines which had been updated in June 2021 were attached to the trolleys as an aide memoire.

Emergency equipment stored in the resuscitation trolleys were single-use, items were sealed and in date. There was an effective system where staff recorded the expiry dates of items which would need replacing and prompted them to place an order in good time. An item that was due to expire at the end of the month had already been delivered and ready to be replaced.

Good

Surgery

In theatres staff carried out daily checks of anaesthetic equipment prior to the start of the surgery list in line with the Association of Anaesthetists of Great Britain and Ireland guidelines. They followed the anaesthetic equipment checklist and recorded this once completed. This also provided assurance that equipment was ready for use and fully compliant.

The hospital did not have any piped gases such as oxygen and nitrous oxide. There were clear procedures that were followed on the wards and in the operating theatre to ensure the gas cylinders were checked and ready for use. Plans were in progress to provide piped oxygen across the premises.

Fire safety risk assessments were completed through a third-party contract. These were supplemented by the Head of Estates completing a comprehensive checklist of fire safety arrangements every three months and each team completing a monthly fire safety risk assessment for their area.

Fire safety equipment was maintained by a third party. All equipment seen was in date for servicing and stored appropriately. Fire doors were in good condition and closed or held open on automatic magnetic closure devices. Fire detection and alarms systems were tested in accordance with the service level agreement and supplemented by weekly in-house testing.

Staff followed their internal process for testing electrical equipment providing assurance that they were safe for use. We carried out a random check of approximately 14 equipment on the wards and the operating theatre. All items we reviewed had a label indicating the device had been tested and included a due date for retest. There was one item in the operating theatre which did not have the safety check sticker. The theatre manager told us this item had been delivered during the pandemic and action will be taken. In theatres, the laminar flow system was tested by an external contracting company. All items checked had passed an electrical safety test within the last 12 months.

Substances that were hazardous to health and safely were in line with Control of Substances Hazardous to Health Regulation 2002 (COSHH). These substances were stored securely and cupboards were locked so cleaning products could not be accessed by unauthorised persons. Staff were aware of the procedures and who to contact in the event of accidental exposure to cleaning products.

The hospital managed clinical waste well and followed guidelines in line with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. They disposed clinical waste safely and removed them from the dirty clinical rooms at regular intervals to reduce infection control risks. Sharps boxes were available and marked with ward's name and date they were assembled. These were not overfilled and the lid closed when not in use to prevent risk of accidental exposures or injuries and were replaced after four weeks or sooner.

There was a third-party contract for pest monitoring and control around the premises. There were no incidents of pests being found on the premises.

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

Good

Surgery

Staff completed risks assessments for patients on admission using national recognised tools. These assessments included risks of malnutrition, fall risk assessment and pressure damage to skin. Care plans were developed using this information to provide care and treatment and minimise risks as identified. Patients at risks of falls or limited mobility were referred to the physiotherapy team for advice and support. Information/ management plan would be included in the care plans for staff to follow.

Patients undergoing elective surgery had a pre- assessment as part of this process. This was a means to identify patient's suitability and other pre-conditions that may lead to patient's complications during the anaesthetic, surgery, or post-operative period.

The hospital used NEWS2, which is the National Early Warning Scoring system developed by the Royal College of Physicians for the detection and response to clinical deterioration in adult patients. This is a key element of patient safety and improving patient outcome. Records showed staff used NEWS2 tool to identify deteriorating patients in the recovery areas and on the wards and any changes were escalated appropriately. The clinical staff had received training and update on the use of the NEWS2 tool and staff felt confident in using it. We reviewed a sample of six NEWS2 records and found these were all completed, and staff were aware of the threshold for initiating medical support as needed.

Staff identified patients at risk of deterioration and acted quickly if their condition deteriorated. The hospital had a service level agreement for the emergency transfer of patients with a local NHS trust.

Patients were assessed for risk of for venous thromboembolism (VTE). Venous thromboembolism (VTE) is a condition in which a blood clot or thrombus forms in a vein, most commonly in the deep veins of the legs or pelvis. The resident medical officer (RMO) completed DVT assessments on patients when they are admitted. Patients were then prescribed DVT prophylaxis such as anti- embolic stocking or other medicines according to their risks.

The service had set a threshold of 95% for venous thromboembolism (VTE) risk assessment to be completed for all patients. The result of this audit in June 2021 showed the service achieved 100% compliance. Between September and December 2020, the compliance was 100% and this information was shared with the clinical commissioning group (CCG) as part of their contract arrangements.

The service had developed policy and procedures to recognise and respond to sepsis (severe blood infection) in line with national guidance. Sepsis is a rare but serious complication of an infection that can lead to multiple organ failure and death if not treated promptly.

We observed application of the World Health Organisation (WHO) five steps to safer surgery checklist for three patients, who we followed with their consent to the operating theatre. The (WHO) checklist is a nationally recognised system of checks designed to prevent avoidable harm and mistakes during surgical procedures. These checks consisted of team briefing, sign in (before anaesthesia), time out (before surgery starts), sign out (at the end of the procedure) and debrief. We observed all five steps of the WHO checklist and saw staff fully completed and engaged in all the required checks. We noted that the WHO checks appeared to be embedded in practice and within the theatre culture.

Theatre staff followed NHS England and the Medicines and Healthcare products Regulatory Agency (MHRA) guidelines and ensured that traceability labels for all instruments and any implants were clearly recorded in the patient's records. We reviewed seven post- operative records and observed three procedures in the operating theatre and were assured this was managed safely. Effective traceability of medical devices was important and allowed for actions that may be required to reduce the safety risks to patients to be carried out in a timely manner.

Good

Surgery

The hospital had undertaken an audit of the of the World Health Organisation (WHO) 'Safe Surgery Checklist' in March 2021. The aim of the (WHO) checklist is to reinforce accepted safety practices and foster better communication and teamwork between clinical staff of all disciplines. The audit reviewed 10 patients' records and recorded the outcome of the observational audit at 100 % compliance. Staff told us that any shortfall would be followed up with an action plan including feedback of the result to ensure any lessons learnt were shared. Audit results were discussed at staff and governance meetings.

The service carried out an audit of the anaesthetic records in March 2021 and achieved 100% compliance. The audit looked at consent, physiological baseline recording of patient, peri- operative and post- operative instructions. These included pain relief, medicines and oxygen prescribed to ensure that patients continued to receive safe care.

The service had developed pre and post- surgery principles and procedure management during COVID-19. There were clear elective surgery pathways which had been instigated during the pandemic and were followed.

Patients admitted for surgery under local anaesthetic or sedation were required to self- isolate for seven days pre-surgery, they were admitted on day of surgery and had one negative COVID-19 test.

The leaders had reviewed and developed new COVID-19 procedures for short -notice admission. In rare circumstances patients could be admitted 48 hrs pre- surgery with a swab completed at that stage. In the event of urgent booked surgery, a finger-prick COVID-19 test would be instigated instead of the swab test. This was part of the service risk assessment and deviation from elective pre-surgery 'protected pathway' management during COVID-19.

Patients' blood results were checked prior to surgery to ensure the procedure could be carried out safely. The service had a designated fridge to store blood products such as (O) negative blood on site for emergency. They had a service level agreement with the local NHS trust to access extra blood products in an emergency.

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.

Managers completed rosters a month in advance and demonstrated that the required number of staff to meet people's needs was provided. We observed the ward area was calm with nurses responding quickly to requests for assistance. Call bells were rarely heard as nurses were checking frequently on patients' needs. We saw that nursing and other staff were walking with patients to show them where to go and guide them to the right area of the hospital. The nurses told us they had adequate staff and support from allied health care professionals to deliver safe care and this included staffing at the weekend. They had two registered nurses on the day shifts and support of health care assistants. Night duty had a minimum of one registered nurse and health care assistants. The duty roster showed the staffing level was above the recommendations for qualified nurse-to-patient ratio. The service used their own staff to cover any shortfall in staffing and bank staff. All staff had a full induction to the service.

In the operating theatre, there was adequately skilled staff to manage the elective surgery list. Theatre manager followed the Association for Perioperative Practice (AFPP) guidelines. The (AFPP) recommended minimum theatre staffing levels of two scrub practitioners, one circulating staff member, one registered anaesthetic assistant practitioner and one recovery practitioner for each theatre list. We observed and records showed that theatre staffing met these recommendations. A senior staff told us they reviewed their staffing the previous day to ensure that the theatre list could go ahead.

Good

Surgery

Feedback from patients indicated that there were adequate staff to meet their needs. Staffing on the wards was reviewed daily for the forthcoming shifts and adjusted according to clinical need and theatre activity. Staff were positive about the staffing and support they received in providing care and treatment. Several staff told us the staffing was good and the duty roster showed the staffing was higher than the recommendation for qualified nurse to patient ratio.

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 daytime and night-time medical cover. The service had contracted two resident medical officers (RMO) who provided 24 hrs cover, seven days a week. The RMO worked on a rotational basis and received a short induction to the service when they joined. Their mandatory training was provided by the agency and records of this was shared with the provider.

The RMO was available for all emergency and reviewed patients at other times. All patients were admitted under a named consultant who had overall responsibility for their care throughout their stays. As part of the practicing privileges agreement, all consultants were required to be available within 30 minutes to attend their patient who required a review. Consultants working under practicing privileges only carried out procedures and surgery in line with their scope of practice and substantive role within their NHS work.

The consultants and anaesthetists were also available out of hours, seven days a week and could be contacted by phone for clinical advice and attended the service as required. The consultants undertook a daily review of the patients under their care and plan of care was developed and communicated to the clinical staff and recorded in the patients' notes.

Records

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment.

Records were stored securely. The service used a paper record system. During the inspection we reviewed 13 sets of patients' records. The records contained detailed information of patients' assessments, including pre assessments and care plans were developed to support staff in meeting patients identified needs.

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. Records seen were accurate, comprehensive and provided a clear picture of the care and treatment each patient received from their initial contact through to discharge.

Patient records were maintained securely in the nursing office and had restricted access to prevent unauthorised access to confidential patients' records.

The theatre records were also comprehensive, contemporaneous and contained details of procedures. The records contained pre-operative assessments, records from the surgical procedure, recovery observations, nursing notes and discharge checklists and assessments which were appropriate to the patient's clinical pathway.

Access to the electronic patients' notes was password protected and staff ensured they logged off when the computers were not in use. We saw surgeon notes were detailed with evidence of daily reviews and clear post-operative management plans. Tests and investigations reports were available electronically and were accessible to staff.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff followed their procedures for transferring outpatients including emergency transfers. Staff made copies of the records which accompanied the patient in order to provide up to date information and maintain continuity in patient's care. An audit of referral records was completed in March 2021 and the service has recorded 100% compliance.

Medicines

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

Staff followed their system and processes when prescribing, administering, recording and storing medicines. Medicines were stored in a locked room, with restricted access to authorised clinical staff. We reviewed the storage of medicines during the inspection and all medicines were locked securely.

The consultant surgeon maintained overall responsibility for patients under their care and any changes in patients' medicines were approved by them or the anaesthetist. There was a clear pathway that staff followed in dispensing to take out (TTO) medicines. There was a clear pathway that staff followed in supply of to take out (TTO) medicines. The TTO medicines packs including dosage instructions were supply by the dispensing pharmacy pharmacist and stored separately. The staff added the name of the patients once this had been prescribed. Two registered nurses checked the medicines prior to supplying them and a record of medicines issued was maintained.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. There was a standard operating procedure for access to the pharmacy out of hours and at weekends which staff followed. This required two staff members access to any medicines in the pharmacy. Staff told us this usually involved the RMO and a senior nurse on duty. Any medicines removed were recorded in the pharmacy register and signed out.

The service also had some medicines that were prescribed and administered from the ward stock. These medicines included pain tablets and antibiotics. There was no record of the number of stock medicines which had been dispensed as stock. The staff told us there was no audit of the stock medicines which may pose risks as the stock medicines could not be effectively monitored.

Medicines rooms and refrigerators were monitored and daily minimum and maximum temperature checks were completed. This was part of the provider's assurance and checks that medicines were stored in line with recommendations. Any concerns were raised with senior team members and staff told us they were effectively resolved.

The service was registered with the Home Office and held a controlled drug (CD) licence as required and in line with the Misuse of Drug Act 1971. This had recently been renewed and expires in June 2022. The service had a CD accountable officer. We reviewed the CD register and a sample of CDs which showed all CDs were stored securely and any CD administered had two signatures recorded as required. Staff carried out daily checks of their CD stock and records were clearly maintained. Staff were clear and knowledgeable about the managements of CDs and ensured that the CD key for example was always kept safely.

The CD audit completed in March 2021 had identified that there had been no pharmacist audit of CDs in the last six months and the CD accountable officer had not undertaken a review of policy and performance in the last 12 months in line with the hospital procedures. At the factual accuracy stage, the provider had told us the audit was due in March 2021 and had not been completed due to the pandemic and this was completed in June 2021, following our inspection.

In the operating theatre, medicines were managed safely. We observed that medicines were drawn for individual patient and no medicines were left unattended in the anaesthetic room. Immediate access to a variety of medicines was essential including intravenous fluids as short delays in medicine availability could make a difference to patient's outcome. A local standard operating procedure should be available to support staff's practices. At the factual accuracy stage, the provider submitted their medicine management policy which detailed procedures for preparation of anaesthetic drugs.

The anaphylaxis box was not clearly labelled, and its contents needed to be reviewed following recent changes, as we discussed with the staff and registered manager during the inspection. Following the inspection, the provider sent us their policy on the emergency management of anaphylaxis which had been reviewed in May 2021 and new guidance added.

The service had contracts with two local pharmacies who provided support and advice to the staff and patients. The service had a pharmacy assistant who supported the clinical staff and was responsible for ordering stock medicines. They also carried out checks on medicines. We reviewed some of the medicines that were in stock and found they were all up to date. Staff had a system to identify and recorded emergency medicines that were nearing their use by date and ordered replacement in good time to ensure patients had the medicines they needed.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.

The service had developed internal processes to report and record incidents. All staff we spoke with knew what incidents to report and followed their reporting system. Incidents were discussed at daily handovers and at staff meetings. Meetings had a standard agenda to discuss any incidents which may have resulted in harm to patients.

The service had not reported any incident in the last 12 months that met the Serious Incident criteria. There was an effective process for investigating any incident that may cause harm to patients. A senior manager undertook a root cause analysis (RCA) following any incident and action plan was developed to minimise the risk of re- occurrence. Investigation outcomes were shared with staff as part of lessons learnt.

The staff we spoke with were aware of their responsibilities relating to Duty of Candour under the Health and Social Care Act (Regulated Activities Regulations) 2014. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify women (or other relevant persons) of "certain notifiable safety incidents" and provide them with reasonable support.

Incident governance processes were effective and gave the hospital leaders and the provider appropriate oversight of incidents and how they were managed. The senior leaders at the hospital understood the reporting requirements and formally reviewed incidents for actions and trends through the monthly senior leadership meetings. Staff were encouraged to report incidents and to use them as a tool to drive improvements. Actions were taken to mitigate the risk of recurrence.

Good

Surgery

Staff were aware of the process for submitting statutory notification of incidents to external organisations and the Care Quality Commission.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. The service declared there were no never events in the last 12 months.

Safety Thermometer

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

The service monitored patient's safety risks such as falls, pressure ulcer and venous thrombosis (blood clots in veins). They had a good track record on providing harm free care. In the reporting period June 2020 and May 2021, the service had reported no hospital acquired infection. They had no incidents of falls with harm and hospital acquired pressure ulcer.

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

Are Surgery effective?

Good

Effective had not been rated previously. It was inspected and rated in 2016 but was then under different ownership. We rated it as good.

Evidence-based care and treatment

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

The service had procedures and policy to ensure that care and treatment was delivered in line with national guidelines such as the National Institute for Health and Care Excellence (NICE) and the Royal college of Surgeons (RCOG) guidance. Examples of guidelines used included management and decontamination of surgical instruments (medical devices) used in acute care HTM 01-01.

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

Patients assessed to be at risk of venous thrombo- embolism VTE (blood clots) were offered VTE prophylaxis in accordance with NICE Quality Safety 3 guidance. The surgery team provided predominantly elective surgery as day cases and inpatient care. Patients had routine pre-operative assessments in line with NICE guideline NG45. This ensured that patient's physiological baseline observations were recorded.

Good

Surgery

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

Staff monitored patients closely following surgery in line with NICE guideline CG50: Acutely ill patients in hospital- recognising and responding to deterioration. We reviewed 10 post-operative patients' records which showed clear evidence of regular observations such as blood pressure, heart rate, pulse and oxygen saturation and were in line with the guidance.

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

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

The service audited staff compliance with their policies and national guidance. This included regular audits on the World Health Organisation (WHO) Surgical Safety Checklist. Audits provided assurances around adherence to the safety checklist and helped identify areas for improvement.

Patients were prescribed prophylaxis which included surgical stockings and injections according to their risks and in line with guidance to prevent blood clots post- surgery.

Nutrition and hydration

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

Information about fasting was provided when patients attended for the pre-operative assessment and prior to surgery. Staff contacted patients 48 hours before their admission and fasting information was shared. The service followed the fasting guidance in line with the national and European Anaesthesia Society recommendation. Patients were advised on intake of clear fluids up to two hours before the induction of anaesthetic as well as six hours fasting for solid food prior to surgery. This ensured patients did not go without food and fluids for longer periods than necessary and reducing risks of aspiration. The pre-surgery checklist contained detailed information according to the type and time of surgery. For example, patients admitted in the afternoon for cataract surgery with sedation were advised to be nil by mouth for six hours prior to surgery and could have black tea or coffee. The service offered patients staggered admissions to ensure they did not fast for longer periods than necessary.

The personal needs or preferences of patients in relation to food were met. Food preferences were discussed as part of the booking process and any cultural or religious requirements such as Halal or Kosher foods were provided.

Food preferences and any allergies were recorded in the care records we reviewed, and this included a patient with lactose intolerance and action taken. The chef saw patients regularly to discuss patient's dietary needs and information was shared with the staff. We always observed patients had access to hot and cold drinks and meals were presented well. Feedback from patients relating to meals were overwhelmingly positive. Staff told us patients were offered support with food and fluids, although most patients did not require assistance.

Good

Surgery

Pain relief

Staff assessed and monitored patients pain regularly and gave pain relief in a timely way.

Patients had access to a variety of pain relief as appropriate for their surgery. This included epidural by injection or oral tablets. Staff completed regular assessments to ensure that patients' pain was controlled and administered pain control as prescribed.

Patients' records showed staff took appropriate actions when patients pain was not well controlled. For example, the resident medical officer (RMO) would be contacted to review patients' pain prescription and liaised with the anaesthetist as necessary.

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

Staff carried out regular assessment of patients' pain and this formed part of NEWS scores Patients records showed a pain assessment was completed and pain relief was offered according to patient's pain score. Medicines records showed patients received regular pain control as prescribed and staff checked the effectiveness of pain relief. Patients received pain relief soon after requesting it. Patients were also prescribed anti sickness medicines to manage the side effects of some pain-relieving medicines. A patient had commented that they were very pleased with the anaesthetist who had looked after them and prevented nausea post- surgery.

Patient outcomes

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

The New Foscote Hospital participated in relevant national clinical audits. Patients were offered the opportunity to participate in the Patient Reported Outcome Measures (PROMs) and submitted data to the National Joint Registry (NJR), for hips and knees. Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to patients. PROMs calculated the health gains after surgical treatment using pre- and post-operative surveys. They also reported to the Surgical Site Infections (SSIs) data collection.

During the period from April 2019 to March 2020, the service had undertaken 26 hip replacements, 27 total knee replacements and a small number of knee revision which was reported as under five.

National Joint Registry (NJR) recorded outcomes at this hospital for patients that underwent hip and total knee replacement procedures. There were three surgeons at this hospital who had submitted their activities to the NJR. Hospitals were required to submit 100% of their eligible information to the National Joint Registry. In the reporting period April 2019 to March 2020, the service had achieved 100% for their NJR submission.

The NJR also reported on the quality of the information submitted by this hospital. This showed the hospital was compliant with their submission of the data to the NJR. The hospital scored 81% for patient consent and just below the expected national rate of 90%. They had exceeded (better than expected) by taking seven days for data submission compared to 30 days national average and achieved 100% for recording a valid NHS patient number. This was important so that the NJR could report an accurate performance to hospitals, the surgeons who work there as well as to patients and the public.

Good

Surgery

Patients were encouraged to participate in these audits if they had received treatment for hip and knee replacements and the service compared their local results with the other provider's dataset and nationally with the NHS

The service had good links with the local NHS service and followed up on the progress of any transfers out and reviewed the care pathway of any patients who may be readmitted within 28 days of having their procedure.

The service also monitored unplanned patient readmission rate. There was one patient readmitted the following morning after discharge due to urinary retention. They were treated and discharged home. There were three patients who were transferred out due to clinical complications and one of these patients returned to the service following observations. There was no reported readmission to any healthcare provider 28 days following discharge from the service.

The staff also carried out regular audit of the National Safety Standards for Invasive Procedures (NatSSIPs). This is a national safety standard aiming to reduce the number of safety incidents for invasive procedures in which surgical Never Events could occur. The latest audit for March to April 2021 looked at five patients' records. The service had achieved 100% compliance in their audit. The audit clearly monitored and recorded when there was any deviation such as the anaesthetist had left as this was a local procedure under local anaesthesia and changes to the theatre list.

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 including the resident medical officer (RMO) before they started work. Staff training comprised of e-learning and face to face with allocated time for training for clinical and non-clinical.

The service had a comprehensive induction programme that included medicines management, infection prevention and control, safeguarding, risk assessments, records keeping and emergency care.

Managers identified any training needs for their staff and offered them an opportunity to develop their skills and knowledge. Staff in the operating theatre had specific induction modules including specific equipment and aseptic technique training.

The RMO, senior operating department practitioners and senior nurses received advanced life support level training. Other nursing and health care assistants completed intermediate life support training. The service had a designated staff member for each department who was identified at the beginning of each shift to respond to the cardiac arrest bleep and support the team.

The service supported staff to undertake training in order to maintain their professional registration and revalidation. Revalidation is a process to ensure staff had undertaken training and development to maintain their skills to remain on the professional registers. Leaders carried out regular checks of the register to assure themselves that staff had current registration in order to allow them to practice. Managers made sure staff attended team meetings and meeting notes were available when they could not attend. The staff had a rolling supervision programme to support them in their work and identify areas of further development.

Good

Surgery

As part of staff development, the provider had established a two-year graduate management training scheme. Applications for the first cohort were open at the time of the inspection visit. The hospital monitored doctors' fitness to practice and required consultants to provide documented evidence of appraisal and revalidation in order to maintain practicing privileges.

The New Foscote Hospital had a practising privileges policy. This document provided details of the criteria and conditions under which licensed registered medical practitioners would be granted authorisation by the hospital to undertake care and treatment of patients.

All consultant staff were required to provide evidence of their accreditation, validation and appraisal before the hospital granted them practising privileges. The hospital Medical Advisory Committee and the hospital director were responsible for granting and reviewing consultants' practicing privileges every two years to ensure the consultants were competent in their roles. The hospital also ensured yearly that consultants had appropriate professional insurance, registration and current licence to practice; an appraisal and personal development plan; infectious disease immunisation status; and their mandatory training was up to date.

Multidisciplinary working

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

The hospital had a service level agreement with a local NHS trust for the provision of critical care service. There were clear agreement and protocol which were followed and agreed by both parties to ensure that transfer of patients to the critical care facility was managed safely and effectively. This included establishing the availability of critical care beds, who the designated receiving consultant was notified by and agreed transfer of the patient. Staff were aware of the emergency transfer protocol and told us the consultant responsible for the patient's care would be involved in the transfer of any patient.

The surgical care pathways were multi-disciplinary and staff of all disciplines developed and supported each other in the planning and delivering of patient's care. Each professional group recorded their assessments and any changes to care and treatment in the patient's records. This provided staff up to date and easy access to information and outcome of the evaluation and the ongoing care of the patients. We observed effective handovers between the staff, pre and post- surgery in the anaesthetic room and recovery area. Post-operative care was shared, and documentation checked to ensure effective and safe patients' care.

The multi-disciplinary team for example attended the daily handovers. The service had an in-house physiotherapist and provided linked up care for patients. The physiotherapy team carried out assessments of patients and developed plans of care and shared information with the nursing team.

Staff worked across health care disciplines and with other agencies when required to care for patients. The clinical staff communicated with the community team such as district nursing team and GP as needed prior to patient's discharge to ensure continuity of care and support. Staff told us that discharge planning followed a multidisciplinary team approach and assessments and this worked well.

Seven-day services

Good

Surgery

The hospital did not provide emergency care. All surgical patients followed the elective pathway and admissions were booked in advance. Staff could call for support from doctors and other professionals such as diagnostic tests were available seven days a week. Consultants were available out of hours, during weekends and would attend the service as needed which was part of their contract/ practicing privileges. Consultants undertook a daily review of their patients and either visited or telephoned the service for an update at weekends. The RMO was the first point of contact and received good support from the consultants out of hours as required.

The operating theatres operated six days a week. They also provided emergency service twenty-four hours a day and seven days a week and had an established on-call rota. This ensured patients received care and treatment in a timely manner to meet their clinical needs.

Allied health professionals including theatre staff, physiotherapy and radiology staff provided care and support out-of-hours. The pharmacist was available six days a week and the staff had access to the pharmacy out-of-hours.

Health promotion

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

Staff assessed each patient's health and well-being at the start of their surgical pathway which began at the pre-admission clinic and advice on smoking risks were discussed. During a pre- assessment for surgery, staff advised patients on smoking cessation, diet and provided support for any individual needs to live a healthier lifestyle.

The national Commissioning for Quality and Innovation (CQUIN) for 2019–2020 encourages hospitals and other settings to deliver alcohol identification. This covers activities including alcohol and tobacco interventions under a prevention of ill health theme. For 2019-20, 80% of patients admitted as a hospital inpatient for one night or more are expected to be 'screened' for alcohol and tobacco use.

Staff assessed patient's health when they were admitted for treatment and provided support for any individual needs to live a healthier lifestyle. This included referral to the relevant allied healthcare professionals as needed.

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.

Staff followed their internal process for seeking consent from patients when providing care and treatment in line with legislation and guidance and this was clearly recorded. In the anaesthetic room, staff gained verbal consent from patients prior to undertaking any procedure.

Staff told us they did not have patients with advanced dementia. However, they were aware of their responsibilities and staff said they would seek advice if patients could not give consent. They would involve others to ensure decisions were made in their best interest and considering the patient's wishes.

Good

Surgery

Staff made sure patients consented to treatment based on all the information available. The service had a two-stage consent process. Patients records showed consents were clearly recorded and nursing staff competed stage 2 of the consent form on the day of their surgery as part of their pre- operative checklist. Staff had received consent training in order to complete this pathway and records showed this was fully completed.

The consultants completed the consent forms with the patients' pre- surgery. The consultant and the anaesthetist visited the patients prior to the surgery to review the patients, share information and answer any queries patients may raise with them.

The service undertook a consent audit in November 2020 and looked at information shared relating to any extra procedures and stage two informed consent documentation had been completed prior to anaesthesia. Records showed that the service had achieved 100% compliance. Staff clearly recorded consent in the patients' records

Are Surgery caring?

Good

Caring had not been rated previously. It was inspected and rated in 2016 but was then under different ownership. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood their individual needs. They involved patients, families and carers in care decisions.

Staff understood and respected the individual needs of the patient. They showed understanding and a non-judgmental attitude when caring for or discussing patients. We observed staff welcoming patients in the reception area and treated them care and were respectful in the way they spoke to patients.

Patients commented positively about their experience of care and treatment they had received at the service. At various times, we observed staff knocking at the bedrooms door and waiting before entering the rooms. All bedrooms were single use with ensuite facilities and staff told us that maintaining patient's privacy and dignity was one of the core values when providing care. Staff in the operating theatre treated patients with care and compassion and ensured their privacy was maintained at all times.

Emotional support

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

Patients who were admitted for day surgery were supported and staff took time to explain the timing for the surgery and explained the procedure to minimise their anxiety. We observed patients were supported in the recovery room, were involved during the handover and their pain assessed. Patients were consulted if they were happy to return to the ward. The discharge sheet was completed, and this was explained to the patient in a calm manner.

Good

Surgery

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff told us patients received a pre-operative call 24 to 48 hrs prior to their planned surgery. This gave patients an opportunity to ask any questions as this could be a stressful time for patients waiting for their surgery and receive support from staff.

Feedback from patients stated that their consultant was very professional and very willing to answer queries and explained everything well. Another patient had commented that the staff were genuine, professional, caring, nothing was too much trouble." Happy to help, delightful and much appreciated when you feel vulnerable".

Understanding and involvement of patients and those close to them

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

Staff on the wards and in the operating theatre took time and made sure patients and those close to them understood their care and treatment. Staff supported patients to make informed decisions about their care ensuring they had information in a timely way. Patients who paid for their care had written information regarding costs of treatment sent to them in advance in order to assist them in their decision.

Patients and their families could provide feedback on the service and their treatment and staff supported them to do this. Patients were sent a feedback form on discharge. Leaders were committed in ensuring patients feedback was used to improve the service. We reviewed the feedback forms between October 2020 to May 2021 and found patients were overwhelmingly positive. Managers shared feedback with the staff and action plans were discussed.

Are Surgery responsive?

Good

Responsive had not been rated previously. It was inspected and rated in 2016 but was then under different ownership. We rated it as good

Service delivery to meet the needs of local people

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

The hospital leaders were working with local commissioners to alleviate pressure on the wider system. The service had regular meetings with the local commissioners and submitted data on performance as part of their contract.

Leaders had worked hard in supporting the local NHS trust during the pandemic. They treated around 3,000 patients and used their elective surgery pathways for oral, vascular access surgeries and endoscopy. They also supported the local trust with pre surgery COVID -19 testing.

Good

Surgery

The hospital offered their services to private and NHS patients. The service worked well with local commissioners and NHS trust to provide coordinated care and meet the needs of local people. They had a service level agreement with the local NHS trust to provide some elective surgery.

Managers monitored and took action to minimise missed appointments and ensured patients who did not attend were contacted. Any cancelled surgery or procedures were promptly followed up and patients were seen by the consultants prior to their discharge. A recent example was when a patient became distressed and chose not to go ahead with their surgery. This was followed up with the surgeon and cancellation was entered in the theatre admission book. Administration staff undertook follow ups and took appropriate actions such as rebooking or referred to the NHS trust.

Staff understood and applied their knowledge and skills on meeting the information and communication needs of patients with a disability or sensory loss. Patients individual needs were assessed at the pre-assessment stage and on admission to ensure appropriate support mechanisms were in place.

Meeting people's individual needs

The cultural competency and identification of staff who understood cultural and religious practices allowed for greater understanding of what was and was not likely to be acceptable.

Patients had good access to the service, the main entrance was fitted with a ramp and automatic doors, a passenger lift and wheelchair friendly environment which supported patient's independence.

The service had a diverse staff team who were able to speak different languages. There were arrangements in place to support patients' diverse needs such as provision of information leaflets in different formats. There were hearing loops to support patients with hearing difficulty and information was available in large prints.

Information leaflets in different languages could be accessed via an external company, although staff said they rarely needed to use this service.

The hospital offered flexible bookings and short referral times to private patients for their care and treatment. The NHS patients used the choose and book system which allowed them flexibility and a degree of choice for admission.

Patients referrals came through different avenues such as privately funded patients had access to treatment by (GP) referral or by self-referral to the service. NHS patients were referred to the hospital by either a GP or an NHS consultant.

Access and flow

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

In the reporting period from June 2020 to May 2021, there were 1,767 day cases and 256 inpatient episodes of care recorded at the hospital.

There were 42% NHS-funded and 58% privately/ insured funded patients.

Good

Surgery

The service monitored their referral to treatment time and looked at clinical and non-clinical cancellations of procedures and treatment. Between June 2020 and May 2021 they had 79 procedures cancelled for clinical reasons. The main reason for the cancellation was patients being unfit for surgery. All patients were rebooked and offered appointment with another surgeon.

There were 162 patients' cancellations for non-clinical reason in the same reporting period. The service monitored cancellations for non- clinical reasons which included patients' choices and procedures which may no longer be needed. The service achieved 100% compliance for 18 weeks for the referral to treatment performance standard (RTT). These included data on urology, trauma and orthopaedic, general surgery, ophthalmology and gynaecology which were the main treatment offered at the service.

Leaders told us the patient pathway team helped smooth the patient journey because they had a small team involved in planning and liaising. This meant any glitches could be quickly resolved. Access to the service was on demand and at short notice and the flow was smooth.

All patients who had their surgery cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons were offered another date within 28 days. Alternatively, the service would fund the patient's treatment at another hospital of their choice as part of their contract with the local commissioning group.

Feedback from patients were positive and they had access to timely appointments, care and treatment to meet their specific needs. We observed the admission of day care patients and this was well managed, and patients were admitted to the wards in a timely manner.

The service moved patients only when there was a clear medical reason or in their best interest and staff followed their procedures and service level agreement to ensure this was achieved safely.

Learning from complaints and concerns

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

The hospital was very open to feedback and minor verbal complaints were dealt with locally and resolved as quickly as possible. The overwhelming majority of the feedback from patients was positive and there were no open complaints. Information on how to raise concerns or complaints was available to patients and their family. The provider offered patients the opportunity for face to face meetings to resolve any concerns.

There was a complaint process that involved a comprehensive review and clinical oversight but it had not needed to be used for some time. The registered manager assumed personal responsibility for any complaints and responded in consultation with those involved. All concerns or complaints were investigated, and any lessons learnt were shared with staff.

The service had a complaint policy and procedure which were available to patients and their family. Where complaints were classified as a stage 3 complaint review this was completed by an external independent adjudication service.

Good

Surgery

Information included how to escalate complaints to the Independent Sector Complaints Adjudication Service (ISCAS). This is voluntary subscriber scheme for the independent healthcare providers which supported patients and provided independent adjudication on complaints.

Data from the service showed that from April 2020 to December 2020, the service had received four complaints and none from NHS patients. There was one complaint which had been referred to ISCAS.

Are Surgery well-led?

Good

Well led had not been rated previously. It was inspected and rated in 2016 but was then under different ownership. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced exceptionally well. They were very visible and approachable in the service for patients and staff.

There was a well-defined leadership structure with clear lines of responsibilities. The directors of nursing for the wards and the operating theatre were responsible for the overall management of these services. The ward matron managed the clinical pathways and supported the clinical and non- clinical staff.

They supported staff to develop their skills and take on more senior roles. Staff spoke very positively about leaders within the organisation and there was a tangible warmth between all grades of staff.

There was very good feedback from all staff about the Director of Nursing/matron and the Head of People, Culture and Talent. They were described as visible, approachable, ever positive, supportive and very hardworking.

The service held a business oversight meeting daily and looked at the hospital's activity levels, staffing, the patient flow and any potential challenges to the system. A member of staff from each department attended; usually the person in charge of the department for the day, although the meeting was not hierarchical. Following the meeting, an e-mail update was sent to the department which was available to the entire staff group. We saw this was printed and displayed at the service to ensure everyone was aware of any changes.

Staff spoke warmly and positively about the registered manager, as a patriarch who cared deeply for all his staff. We were told he was open to challenge and debate or discussion and that he listened to the views of others. He knew every member of staff very well and was said to be respectful and kind. He had a very good grip on the quantitative data around the performance of the hospital and of the performance of individual consultants with practicing privileges. He told us that he was keen for people to learn from any shortcomings or mistakes through reflection and ownership of performance but was not prepared to accept poor performance where the individual was not prepared to change their practice. He was very focused on excellence and patient safety.

Vision and strategy

Good

Surgery

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

The hospital had a vision and strategy to:

- Deliver quality, evidence-based healthcare for our patients.
- Engage and communicate with our patients to ensure we offer the best patient choice and patient-centred treatment.
- Demonstrate a commitment to learning, innovation and education of the highest national standards.
- Continue to develop and maintain clear and efficient processes to facilitate effective corporate and clinical governance.
- Value, develop and engage our workforce to main high professional and personal wellbeing.
- Continue to re-invest in the hospital and the services.

The hospital had plans in place and was working towards these aims. We saw many examples of these during the inspection. For example, there had been heavy investment in the facilities and equipment to make sure patients were comfortable; the best infection, prevention and control (IPC) practice was followed; and staff and patients had up to date equipment.

Staff told us they had seen “dramatic changes” since the new owners had taken over the hospital and had started to deliver on the hospital’s vision and strategy. Staff said they were committed to working alongside the senior management team to improve the service for all patients.

The leadership team worked with other local stakeholders to inform and influence the development of services across Oxfordshire through their commissioning contracts.

Leaders and staff understood and knew how to apply them and monitor progress. Future plans were well researched, with commitment to growth and improvement at a sustainable pace.

Leaders were committed in the development of their staff and recruitment. The team spoke about the commitment in staff development such as the graduate scheme programme and how this was a positive step in developing their own staff. The provider was working on strengthening the relationships with stakeholders and commissioners.

The vision for surgery was to expand the operating theatre facilities and add an extra theatre suite. Plans had been developed and submitted for approval. The provider was planning on developing the muscular skeletal service and staff member had been supported to undertake an imaging course as part of the development of this service.

Culture

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

Every member of staff spoken to reported confidence that their line managers would listen to any concerns they had. Leaders at all levels reported that would feel supported to address any issues or concerns they had identified, or which were shared with them. This included where concerns involved other leaders or other departments.

Good

Surgery

At every level, the culture was described as 'family-like' professional but warm. We heard where the provider and the hospital leaders had been very supportive of individual staff and shown extreme kindness when someone was facing difficulties.

We heard about and saw examples of how specific serious concerns were being appropriately addressed by the registered manager and Chair of the Medical Advisory Committee. Most had preceded the timeframe for this inspection but showed an intolerance of poor behaviour amongst senior staff and consultants with practicing privileges. Whilst this had created some turmoil as the hospital transitioned from charitable status to private ownership, the very positive impact was evident in the relationships, behaviours and team confidence that we observed.

The organisational values were displayed throughout the service and were known to staff. The three key values had been decided by a vote that was open to all staff working at the hospital. The agreed values were:

- Professional service
- Clinical Excellence
- Quality Care

Underpinning the organisational values were a series of civic responsibilities. These too had been subject to a vote by staff before being agreed as:

- Compassion
- Innovation
- Vigour
- Integrity
- Community

The way the civic responsibilities were enacted was through explicit personal attributes such as positivity, kindness, trust, teamwork and reliability.

The civic responsibilities were used as part of the organisational people management systems from recruitment and induction through to review meetings and annual appraisals. They were embedded in all areas of practice.

The service promoted equality and diversity in daily work and provided opportunities for career development. This was a real strength of the service. There was some report of historical racism amongst people who had worked at the hospital previously. However, there had been a complete change of culture such as recruitment from diverse groups.

The registered manager and leaders were committed to be a fair employer who celebrated diversity. The demographic for the hospital staff group showed that there was proportionate representation of people from non-white British communities at all levels of the organisation. The proportion of non-white staff in more senior posts was higher than in the local community.

The provider had signed up to the Race at Work Charter and the Disability Confident Charter. They were working towards the Investors in People award. This is an improvement tool designed to push forward an organisation's performance through its employees. It helps organisation to improve performance and realise objectives through the management and development of their people.

Good

Surgery

At the start of their employment, staff were asked to complete a cultural competence questionnaire. The information could be kept private if people wished, but with permission, was used to improve patient and staff experiences. An example was a register of which languages were spoken by which staff. This could then be used to ensure patients had access to someone who could interpret or speak their own language informally throughout their pathway. New members of staff could be supported by someone with a shared heritage.

In April 2015, after engaging and consulting with key stakeholders including other NHS organisations across England, the Workforce Race Equality Standard (WRES) was mandated through the NHS standard contract, starting in 2015/16. From 2017, independent healthcare providers were required to publish their WRES data. At the factual accuracy stage, the provider submitted a WRES report dated 3 August 2021. This showed there were 24 out of 66 staff who were identified as black minority ethnic (BME). According to the report there were no data available for the previous year and the service was working on an action plan to meet the WRES recommendations.

The hospital had a multi-cultural and multi-ethnic workforce that was valued, and they felt respected. We did not receive any data on WRES as requested to assess any trends and feedback.

The New Foscote Hospital was producing a monthly magazine that informed staff of the latest healthcare news, local information and staff stories. This included a section on new starters so current staff knew who had joined the team and in what capacity and a section where they celebrated staff news, whether it be birthdays, retirement or new babies. This demonstrated that the hospital was eager to be an inclusive employer.

Governance

Leaders ensured that there were 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.

Each department leader had a strong grasp of their area of responsibility as well as a shared understanding about the work of the wider hospital team. The finance director understood theatre staffing, the estates leader understood patient safety, for example.

Data was used at all levels to provide assurance of compliance with legislation and to demonstrate adherence to best practice. The service had a comprehensive assurance system for infection prevention and control which enabled performance issues and risks to be reviewed.

Staff recruitment processes ensured patient safety. All staff completed a robust recruitment process that had all information recorded on a secure database.

Consultants were offered practicing privileges after appropriate checks had been completed and approval had been given by the Medical Advisory Committee. At the time of the inspection there was a waiting list of consultants who wanted to practice at the New Foscote Hospital. The provider was clear that the number of practicing privileges would be restricted to ensure that they could meet the demand and provide a high-quality service. There was documentary evidence that practicing privileges would be withdrawn if there were concerns about the clinical practice of individual consultants or their behaviours.

Managing risks, issues and performance

Good

Surgery

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 copewith unexpected events.

The hospital had an operational risk register where all risks across departments were recorded. There was evidence of reviews and action plans were initiated to manage the risks identified. They used a traffic light system of red, amber, green and blue with red being the highest risk and blue denoting completed/resolved. One of the risks identified for the operating theatre related to the safe handling and transportation of liquid nitrogen. Risk assessments had been completed and liquid nitrogen were in place.

Leaders in the theatre team knew their service well and shared a common sense of the areas of potential risk. Where we identified and discussed potential risks, we were shown that the provider was already aware and was taking steps to reduce any risks. An example was around the very recent changes to national guidance on anaphylaxis. The provider had received the new guidance the previous week and had booked a discussion meeting to review their policy and make any necessary changes.

There was an ongoing recruitment process which was followed and there was no recorded risk around staffing. In addition to internal governance process, the hospital was monitored by the Clinical Commissioning Groups (CCG) as 42% of their work was with NHS patients. They were subject to the NHS standard contract requirements which set clear expectations around the quality of service and reporting systems.

As part of the process specific performance indicators required under the Commissioning for Quality and Innovation (CQUIN) scheme for 2019/2020 must be met. Failure to do so can result in reduced payments. The service had developed policy and procedures for assessing their performance and reporting on CQUIN. Leaders told us that the current data was not available due to the pandemic.

Leaders had reviewed their procedures to support the elective surgical pathway and making it as accessible and safe. Patients were required to have a COVID-19 test 72 hours prior to their planned surgery. They then had to self-isolate before surgery and tested on admission.

One mantra of the hospital was that it was better to run smoothly and safely than to be understaffed or poorly equipped. The hospital was very well resourced and if something was needed, it was purchased. Similarly, if an increase in staffing was needed this was provided. Resourcing was generous to ensure the hospital could attract high quality staff and provide a positive patient experience.

The provider had engaged the services of an occupational health specialist and an employee assistance programme to support staff and managers through the pandemic and beyond. Staff could self-refer, and the service included access for direct family members. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Managing information

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

Good

Surgery

Staff were able to access information on their local intranet, which included clinical policies and standard operating procedures. Other information included leaflets on effective infection procedures and control for COVID-19, and information to support a patient giving informed consent which staff could print from the intranet. For example, information about joint replacement was available.

The patient on discharge received a letter that included details of their surgical procedure, findings, medicines and any changes and details of any follow up. The service sent a copy of this letter to the GP and placed a copy in the patient's medical records at the hospital.

The provider used data to monitor quality, drive improvements and build their strategy and business plans. The provider was looking at upgrading of the hospital IT system to an up to date system and moving towards e-records.

Thorough market analysis had been commissioned to enable the provider to determine what services were most needed and where growth would be useful to the local health and social care economy. For example, the current hire arrangements for MRI scanning were at capacity. The volumes and costs were monitored and it was decided that it would be viable to purchase and staff their own MRI scanner to support diagnostic work for their own patients and for patients from local NHS services.

Performance data was collated and used to ensure patient's safety. An example given was a consultant who had their practicing privileges cancelled because of several patients' safety incidents that the consultant was dismissive of.

The hospital was one of 300 NHS and private hospitals currently working with Private Healthcare Information Network (PHIN) who published independent, trustworthy information to help patients make informed treatment choices. We were told leaders regularly supplied key data about their consultants, procedures and outcomes as specified by the Competitions and Markets Authority (CMA) to provide transparency and share vital information for prospective patients. However, when we reviewed PHIN data for the New Foscote Hospital limited information was available on the website regarding the New Foscote Hospital.

Engagement

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

The provider worked through formal agreements with both a local NHS trust and the lead CCG to deliver services to support the local healthcare economy. During the COVID-19 pandemic, stronger and more effective communications had formed especially with the local NHS trust. A weekly call between the hospital and the trust had been set up where services were reviewed, and improvements made if necessary.

Patients were encouraged to provide feedback of their care and treatment and this was an area that staff told us they were all committed to contribute to and from the feedback to improve the service. Each department provided patients with 'How are we doing' feedback form. Patients were sent a feedback form which gave them the opportunity to provide further feedback in more detail after their care or treatment. Patients feedback were reviewed and shared with staff each month and then on quarterly basis.

The staff survey results from the March 2021 survey were exceptionally positive, as were the exit interview reports we viewed. The results showed 100% of staff reporting that they were proud to work at the New Foscote Hospital. Staff approached the leaders confidently and warmly; they described the team as being like a family.

Good

Surgery

All the comments seen on the staff questionnaire were positive about the hospital as a workplace and provider of care and treatment. Engagement started from the point of recruitment and as part of the induction programme, the Head of People, Culture and Talent met with new starters after their first week to ensure all was well and to seek feedback.

There was a 'Please Welcome' email message sent to all staff when the hospital had a new starter. The email shared a photograph and brief biography about the new member of staff, to encourage current staff from across the hospital to say hello and introduce themselves.

The provider was introducing a series of personalised cards for staff. There was one for new starters that would be sent a week or so, before they took up their post from the team they were joining, to welcome them to the team. There were work anniversary cards and cards for other special life events and celebrations. There were also goodbye and good luck cards for departing staff.

Several staff members talked to us about the work they had been supported to carry out in the community and with other providers during the pandemic.

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 supported the staff to develop this.

One of the aspects of the vision was to encourage a reflective culture, to support staff to learn from their own practice and that of others and to drive continuous improvement through reflection

Innovation was one of the civic responsibilities for the organisation. One example was the development of patient pathway team. This was a team of seven co-ordinators working under a patient pathway manager. The team had been created from several staff roles to provide a multi-skilled team who could work across the entire administrative support function of the hospital.

The team members took the initial contact call and could offer comprehensive information about the intended treatment including usual costs, what was involved, dates of next appointment and surgery up until discharge. They covered reception, the ward clerk role and administration. The service was participating in the early mobilisation and discharge of orthopaedic patients.

The advantage was that it built in greater organisational resilience and improved staff confidence and opportunities. It also allowed for more personal care with patient pathway co-ordinators visiting patients to say hello, when they were admitted and meet them when they are back for follow up visits. It created confidence in the patients and meant they ask questions they might not otherwise do. The patient pathway team now ensured that 98% of calls were answered within two rings and the person who answered was able to address the query.

The provider had established a two-year Graduate Management Training Scheme. Applications for the first cohort were open at the time of the inspection visit.

The provider had assessed the operating capability and plan to develop a second theatre suite, planning application has been submitted and this was awaiting approval.

Good

Medical care (Including older people's care)

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

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

Good

Safe had not been rated previously. It was inspected and rated in 2016 but was then under different ownership. We rated it as good.

Mandatory training

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

Staff received and kept up to date with their mandatory training.

We saw training records that showed 100% compliance with all the required training for staff working in the endoscopy unit. The provider was moving from one records database to another, which meant that the records were on two places, but when collated it was clear all staff were trained. Individual staff files confirmed that training had been completed. Staff told us they had completed training. From the 14 May 2021 all employee records would be moved to the new database.

Staff completed face to face and online modules tailored to their role including health and safety, manual handling, basic life support and infection prevention and control. Staff felt training was comprehensive and met the needs of their role.

A dashboard showed when individuals' training was due to be completed and an alert notified the staff member and their manager and the head of people, culture and talent.

For our detailed findings on Mandatory training, please see under this sub-heading in the surgery report.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff received training specific for their role on how to recognise and report abuse.

Good

Medical care (Including older people's care)

Records showed that staff completed safeguarding adult and safeguarding children training appropriate to their roles. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Examples given including working with the clinical commissioning group and NHS trust to ensure that referrals were able to have their needs met at the hospital.

Staff knew how to make a safeguarding referral and told us they would inform the lead endoscopy nurse in the first instance, if they had concerns. The endoscopy nurse was the senior member of staff in the department and had good access to the matron, the organisational safeguarding lead, for advice.

There were appropriate, current policies for the hospital that informed staff about best practice and hospital protocols for dealing with abuse or neglect concerns. Policies referenced national guidance and local health and social care system arrangements.

Cleanliness, infection control and hygiene

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

The clinic had a comprehensive risk assessment which considered the additional impact of the COVID-19 pandemic. This was reviewed and updated in line with new government advice and guidance.

Clinic areas were clean and had suitable furnishings which were clean and well-maintained. The flooring and walls were impermeable to liquid and in good repair, which allowed proper disinfection.

There was a handwashing sink in each room, which was compliant the national guidance, along with hand gel and instructions for use. Staff routinely decontaminated their hands in line with provider guidance.

All staff had completed a training course about the correct use of personal protective equipment (PPE). Staff followed infection control principles including the use of PPE during our observations. Audits of PPE use showed 100% compliance.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Equipment had stickers to ensure staff knew it was clean.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. There was a review of the endoscope decontamination facilities conducted by an external person which took place in September 2020 and showed all actions had been completed.

An end of list check was recorded to ensure that all necessary cleaning and decontamination processes had taken place. This included records that all unused sterile water was discarded, that diathermy leads had been cleaned and that scopes had been processed and packed ready for transporting to the decontamination unit.

Environment and equipment

Good

Medical care (Including older people's care)

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 endoscopy clinic met the standards for accommodation for day care endoscopy unit; for example, there were dedicated rooms for segregation of clean and dirty equipment.

The endoscopy suite had one endoscopy room, three recovery rooms and one sluice room. There was also a pathology laboratory situated within the suite, which processed samples from within other areas of the hospital which was not accessible on the day of inspection.

The environment was appropriate, and patient centred. There was a patient toilet, handwashing sink and shower for each room, along with a television and a lockable cupboard to store belongings.

There were call bells in the recovery rooms which patients could reach. During our observation of the unit and ward areas, staff responded very quickly when called. There was no noise from unanswered call bells and staff checked on patients frequently, reducing the need for the call bells to be used.

Staff carried out daily safety checks of specialist equipment. Records showed these checks were completed without exception.

There were plentiful supplies of all necessary consumable equipment, with staff telling us that if they needed anything it was provided.

There was a service level agreement with a local NHS hospital to provide endoscopes and to decontaminate endoscopes after use. The endoscopes were collected and then returned each day by a porter using a process that minimised risk of cross contamination.

There was a system for staff to acquire additional endoscopes outside of the normal agreement. Equipment could be provided for additional clinics or an emergency procedure within an hour of it being requested.

Loan endoscopes were managed through a commercial track and trace system with serial numbers recorded on a database that was ISO Standard 9001 accredited.

There was a system to ensure maintenance and quality assurance of equipment. The service had recently installed a new endoscope tracking and tracing system to record each stage of the decontamination process for each endoscopy procedure. The system tracked the people involved, storage and subsequent patient use for each scope.

The provider contracted with a local hospital to provide decontamination of the endoscopes. We saw that endoscopes were transported in accordance with the provider protocol and that the decontamination centre had been accredited through a national programme. The provider told us a recent audit by an external adviser showed the decontamination arrangements were safe.

There was resuscitation equipment readily available and appropriate to use in the endoscopy environment. All resuscitation equipment was checked daily.

Staff disposed of clinical waste safely. There was locked secure storage for clinical waste bags awaiting collection. A contract with a third-party contractor allowed for regular waste collection. This had been increased during the pandemic to allow for greater amounts of clinical waste to be managed safely

Sharps boxes were provided in all areas; these were correctly assembled, labelled and not overfull.

Assessing and responding to patient risk

Staff completed and updated care plans for each patient and removed or minimised risks. Staff used an adapted version of the World Health Organisation (WHO) Surgical Safety checklist to ensure the right person received the right procedure. Routine checks were carried out before each procedure, to ensure that it was the correct patient, the correct procedure and that consent had been obtained.

There was a morning briefing when all staff working that day received information about the patients due for procedures as well as confirmation that equipment checks had been completed. A daily briefing was read aloud before and after each list. This included a pre-list check that all necessary endoscopes were ready and confirmation of expected procedures. Post list briefing included confirmation that a WHO Surgical Safety Checklist had been completed for each procedure and that if there had been gaps or any changes to the list, these were recorded as incidents.

There were processes to direct patients to appropriate care, if they have a complication post procedure. If complications took place on site, patients received appropriate emergency care and would be transferred to a local NHS emergency setting. This had never been necessary and no incidents relating to procedural complications had occurred.

The hospital had well embedded processes for responding to unexpected deterioration in a patient's condition. The small size and co-location of the unit meant that senior support was readily available. Staffing levels allowed for close monitoring of each patient and a rapid response to any changes. Staff completed and updated care plans for each patient and removed or minimised risks.

Clinicians were advised promptly of any abnormal results that indicated a risk to patients' health Samples were processed through laboratories within nearby NHS hospitals and independent laboratories, with whom there was an agreement. Abnormal results were highlighted or 'phoned through to clinicians.

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.

Consultant level doctors were employed through a practicing privileges agreement. The granting of practising privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic.

The provider had developed practicing privileges within the organisational governance model and quality systems and against the context of the requirements of the current regulatory framework. Privileges were monitored, reviewed and revised within the professional governance framework and against the context of person-centred safe and effective care. Files seen demonstrated careful consideration of the suitability of each practitioner by the provider and through the Medical Advisory Committee.

Good

Medical care (Including older people's care)

The registered manager had oversight of individual consultant performance and acted whenever concerns were identified. This included an invitation to discuss behaviour or performance in the first instance, where their concerns appeared minor. More serious concerns or a failure to engage with the provider around ongoing concerns resulted in formal disciplinary action and a suspension or cancellation of practicing privileges.

The provider had reviewed the number of consultants with practicing privileges to ensure that they could meet the needs of the service and the consultants were working sufficient time to be confident in the setting and with local policies. There was a moratorium on practicing privileges in some specialties that were over-subscribed and new appointments were only being offered where there was an identified shortage.

Staffing met the recommendations of the British Society of Gastroenterology (BSG), Joint Advisory Group (JAG) and Royal College of Anaesthetists (RCA) with regards to number and training in life support. There was one current vacancy for a clinic nurse which was covered using regular bank nurses who knew the hospital well. Staffing levels were being increased as demand increased.

There is one lead endoscopy nurse, two clinic nurses and one assistant practitioner (an assistant practitioner is a non-occupational specific role that has been developed to assist organisations to deliver high quality, patient-centred care in a variety of settings). The service also used regular bank nursing staff. There was a porter who was responsible for transporting the endoscopes to and from the clinic.

The service currently carried out around 10 endoscopy procedures per week for patients over the age of 18 years but was looking to expand the service to meet demand.

Sickness rates for staff were low. There were no cancelled procedures due to a lack of medical or nursing staff.

The service used the same bank staff on a regular basis. Recruitment checks had been completed along with induction and mandatory training for bank staff.

Administration was carried out by patient `pathway navigators who were multi-skilled and provided support functions across the 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.

The service conducted regular audits of patient records to ensure compliance. Records were available electronically and in paper form.

Patient notes were comprehensive, and all staff could access them easily. Records were maintained in good order, with papers filed in appropriate places and no loose sheets that could be lost. Staff wrote legibly and had signed and dated their entries. All records seen contained comprehensive risk assessments, copies of patient letters, instrument barcodes and necessary checklists.

An endoscope workflow system stored records securely and was integrated with the main hospital records system.

Medicines

Good

Medical care (Including older people's care)

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

Staff stored and managed medicines and prescribing documents were in line with the provider's policy. Medicines were drawn up individually for each patient. Controlled drugs use was monitored daily.

Staff followed current national practice and guidelines were followed for people who needed sedation for their procedure. A local standard operating procedure was available to ensure that minimum standards for the delivery of sedation and anaesthesia were maintained in line with the recommendations of the Royal College of Anaesthetists.

An end of list check was recorded to ensure that all necessary processes for the safe management of medicines had been completed. These included records of the disposal of any unused medicines, accounting for controlled drugs and re-ordering of any medicines that were required for future use.

There was a system standard operating procedure and process for medical gases. At the time of the inspection piped oxygen was not available, but we saw plans and contracts that demonstrated that the provider was installing piped oxygen throughout the premises. There were adequate numbers of oxygen and other medical gas cylinders readily available, to ensure that patients who needed it, received it. Medical gas cylinders were supplied safely, and stocks were checked routinely.

Incidents

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

Staff raised concerns and reported incidents and near misses in line with provider policy. Managers debriefed and supported staff after any serious incident. Staff kept records of reported incidents and the action taken to ensure that these were used as opportunities for learning.

If the WHO Surgical Safety Checklist was not fully followed there was an explicit expectation this was recorded on the briefing sheet and logged as an incident.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. There were no examples relating specifically to endoscopy, but staff were aware of other situations and the action that had been taken to prevent recurrence.

The service had not reported any never events or serious untoward incidents in the last year.

Staff understood the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. There had been no incidents that reached the threshold for the duty of candour to be a requirement, but the provider tried to ensure staff were always open with patients.

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

Good

Medical care (Including older people's care)

Good

Effective had not been rated previously. It was inspected and rated in 2016 but was then under different ownership. We rated it as good.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance from the Royal Colleges and from the National Institute for Health and Care Excellence.

Protocols and policies were provided which referenced relevant guidance.

The daily end of list record showed that there was due consideration of whether provider policies and best practice guidance had been adhered to.

Nutrition and hydration

All patients who booked for an endoscopic procedure were given Information about pre-procedure fasting, special dietary requirements and other preparation. The time of the last food or drink consumed was checked prior to the procedure commencing.

Whilst many patients did not need to fast, where there was a requirement there were patient specific instructions.

Patients were offered a drink and a snack following their procedure.

Pain relief

Patients were given pain relief, if required. Local anaesthetic spray was used to numb throats prior to a gastroscopy. Sedation could be given, if required.

Staff checked if patients were comfortable and then prescribed, administered and recorded pain relief accurately, if needed.

Patient outcomes

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Information from the local audit programmes was used to improve care and treatment.

Comprehensive reviews of patient outcomes for each procedure and for individual consultants were undertaken and used to benchmark practice and assure the provider that patients were having good experiences and outcomes. The provider used these to monitor and ensure the safety of services and compliance with practicing privileges.

Good

Medical care (Including older people's care)

Improvement was checked and monitored. There were systems to monitor and improve outcomes from upper gastrointestinal bleeds and mortality through audit and comparative data.

The provider identified and investigated any changes to patient outcomes with the consultants and through the Medical Advisory Committee to understand avoidable harms and to encourage best practice guidance was followed.

The service was working towards registering for accreditation by the Joint Advisory Group for Gastrointestinal Endoscopy (JAG).

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. Individual staff records showed an ongoing assessment of competence. Files seen demonstrated that the provider had checked all staff qualification before appointment, including for consultants offered practicing privileges.

There were annual appraisals that included a requirement to discuss performance and learning. Consultants were required to provide evidence from their NHS appraisal, where they held substantive contracts. Their scope of practice was very clearly defined, and consultants were only permitted to undertake procedures where they had a proven ability and sufficient experience.

Managers gave all new staff a full induction tailored to their role before they started work. There was a structured induction, training and re-validation programme for staff involved in decontamination using a competency assessment tool.

Managers supported staff to develop through yearly constructive appraisals of their work. Staff felt there was clear career progression available within the organisation.

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

The provider monitored and reviewed the performance of the consultant endoscopists against key performance indicators and ensured they received feedback.

All decontamination staff were trained and held demonstratable competencies for their role. The appointed decontamination lead was the lead endoscopy nurse.

Managers made sure staff attended team meetings or received a copy of the meetings notes by email when they could not attend.

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

Multidisciplinary working

Good

Medical care (Including older people's care)

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

Patients had their care pathway reviewed by relevant consultants.

Health promotion

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

Where abnormalities or risk factors were identified, patients were referred to their GP for additional support.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available and ensured people who had limited use of English had interpreter to ensure that consent was informed. Consent was clearly recorded in all the patients' records that we reviewed.

The adapted WHO Surgical Safety Checklist was in use within the department and included a check that valid consent had been obtained for the procedure that was to be undertaken.

Verbal consent was obtained at each step in the process.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. When patients could not give consent, staff made decisions in their best interest considering patients' wishes, culture and traditions.

Children under eighteen years of age were not offered treatment in the endoscopy unit.

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

Good

Caring had not been rated previously. It was inspected and rated in 2016 but was then under different ownership. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood their individual needs. They involved patients, families and carers in care decisions.

Staff were discreet and responsive when caring for patients. Chaperones were available.

Staff maintained the privacy and dignity of patients having procedures. Changing facilities including showers and lavatories were available in each endoscopy room.

A Dignity Policy had been introduced and was circulated to all staff. This was shared with staff in April 2021. There were also dignity champions appointed including a representative from the unit.

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.

The hospital felt very gentle, calm and quiet. They were busy but there was no sense of being rushed or not having the time to spend with patients. Staff smiled and said hello to everyone. There was no suggestion staff of any grade were too busy to be interrupted.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. The staff group were diverse and more ethnically diverse than the local population. There were about fourteen languages spoken by staff across the hospital which meant usually someone could speak with people in their first language. Professional staff were used for interpreting, or a telephone interpreting service was available Staff considered preferences such as food choices, religious fasting periods, and women only staffing for intimate care and treatment.

A strong commitment to ensuring that people from all ethnic backgrounds felt comfortable and well supported was a real strength of the hospital.

Patients gave positive feedback about the service and there was a system to ensure t feedback was measured, reported and actioned. Feedback included positive comments about the caring attitude of staff and their ability to put patients at ease. We saw numerous thank you emails and letters thanking staff in the unit for their positive support. We also spoke with patients, who were equally positive.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff built rapport with patients and demonstrated kindness, compassion and empathy when having difficult conversations. They did not rush patients and gave them time to feel settled and to ask any questions before and after their procedure.

The patient care co-ordinators were usually the first point of contact for patients and came to know many of them quite well. They tried to ensure they met them when they were admitted, to say hello and sought them out when they attended for follow up appointments.

Staff described a family atmosphere where patients needs were central to all that happened in the hospital. Staff around the hospital approached visitors and patients to offer help rather than waiting to be asked.

Understanding and involvement of patients and those close to them

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

Good

Medical care (Including older people's care)

Staff made sure patients and those close to them understood their care and treatment. Staff took the time to ensure patients had their needs addressed and understood what was going to happen. Patients' families and friends were not permitted into the clinic during COVID-19; however, families and friends could dial in to a video consultation so that they could be present when the patient received their results from the consultant.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. A local survey for endoscopy sought the views of patients using the service and provided ongoing feedback. There were feedback forms available in the endoscopy suite for patients to complete.

Appointments allowed time for patients to ask questions prior to and after their procedure. Patients understood how and when test results would be received. Patients were provided with written information and advice on discharge. Leaflets were given to patients on booking.

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

Good

Responsive had not been rated previously. It was inspected and rated in 2016 but was then under different ownership. We rated it as good.

Service delivery to meet the needs of local people

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

Currently, medical care at the hospital comprised the endoscopy service on the ground floor of the hospital. The service offered gastroscopy and colonoscopy services to private patients.

The service currently carried out around 10 endoscopy procedures per week for patients over the age of 18 years but was looking to expand the service to meet demand.

Managers planned and organised services so they met the changing needs of the population. The provider commissioned comprehensive local market analysis and business planning to learn local needs and priorities. There were agreed plans to expand the service as demand rose.

The service offered support to the local NHS trust directly and via the clinical commissioning group to enable faster access to endoscopy for NHS patients awaiting a diagnosis.

Facilities and premises were appropriate for the services being delivered. The site of the hospital was adjacent to a local district general hospital, allowing for rapid transfer, should it be necessary. The endoscopy rooms were suitable for their purpose and well equipped. Onsite parking was available close to the front door which meant patients who had been sedated could be collected from very close to the unit.

Staff ensured that patients who did not attend appointments were contacted. The patient pathway co-ordinators followed up all patients who failed to attend.

Good

Medical care (Including older people's care)

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.

Consideration of individual needs and preferences for both patients and staff were a strength of this service.

A cultural competency assessment was requested from staff as part of their joining process. This enabled the provider to understand the skills that individual staff could offer and was used to identify staff with specific language skills and those with an understanding of the likely needs of people from various ethnic or religious communities. This helped ensure the needs of people from non-white British backgrounds were met.

Staff made sure that patients could get help from interpreters or signers when needed. This included access to a British Sign Language Interpreter.

Individual support was provided when required or requested by people with sensory loss and was carried out in a way that the patient preferred.

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

The provider had also taken steps to address a lack of women consultants and consultants from ethnic minorities who had historically been denied privileges. This resulted in greater choice for patients who might prefer a same sex consultant.

The premises were accessible for those with limited mobility. The endoscopy suite was accessible by lift or stairs. There was entirely level access from the car park with a permanent ramp into the hospital and lift call buttons at an accessible height. Disabled parking was available very close to the hospital entrance. The premises had enough space to allow easy movement for people who used a wheelchair or other mobility aids. Doors were wide and corridors free of obstruction.

Access and flow

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

Waiting times from referral to treatment were minimal with patients waiting around one week. Patients were offered a choice of appointments. The patient pathway co-ordinators were in daily contact with endoscopy staff to ensure that patients wishes could be accommodated when booking them for procedures.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and targets. Additional clinics were added according to patient need. The service maintained a weekly utilisation record that showed the number of patients due for procedures, the number who had procedures, the list size along with start and finish times and any incidents recorded.

The endoscopy team had ready access to expert support and the right equipment in the event of any emergency and were well versed in emergency protocols. The service was sufficiently flexible to allow for individual needs to be met and for a swift appointment to be arranged, when necessary.

Good

Medical care (Including older people's care)

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 knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern. Feedback was actively sought from every patient and the patient pathway co-ordinators followed up patients to ensure they were content with their care and treatment.

Staff understood the policy on complaints and knew how to handle them, although there had been no formal complaints about the endoscopy service.

Managers investigated complaints and considered themes but there were insufficient complaints raised to make this a valid analysis. Each complaint was considered by the director of nursing and the registered manager personally. There was a very low tolerance of poor care or treatment and the culture was to provide very high-quality care and communication.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation of their complaint.

Staff gave examples of how they used patient feedback to improve daily practice; this was less about learning from complaints and more about taking lessons or ideas from the feedback forms that patients completed. The example given was about a complaint about the booking process. All staff spoken to were aware of the changes to the process because of this complaint.

Are Medical care (Including older people's care) well-led?

Good

Well-led had not been rated previously. It was inspected and rated in 2016 but was then under different ownership. We rated it as good.

Leadership

Leaders at all levels 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. This included ensuring that leaders at all levels reflected the diverse workforce and there was no cultural imbalance.

There was a clear leadership structure from service level to senior management level. The owner of the hospital was the registered manager for the service.

Good

Medical care (Including older people's care)

Staff described the senior leaders as being very supportive and readily available. They all said they felt comfortable raising concerns and knew they would be listened to. We observed positive relationships between leaders and manages and staff of all grades and professional disciplines. The registered manager operated an open-door policy, was greeted warmly by staff and was said to be open to staff disagreeing with him.

Staff commended the visibility of the registered manager who they felt had high expectations and insisted staff delivered good care. He was described as very fair

The lead endoscopy nurse had responsibilities for overall management of the clinic. All staff identified the lead endoscopy nurse as the person they reported to. Staff told us that the lead endoscopy nurse was visible. We were also told that staff had received good support from leaders during the COVID-19 pandemic. Staff told us they supported each other. We heard from one staff member about the exceptional kindness shown by hospital leaders to another member of staff who was unwell during the pandemic.

Vision and Strategy

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

Staff told us they were aware of the overall vision and strategy for the hospital and that they felt part of that vision. There were records and reports from ongoing engagement and consultation with key stakeholders about future service development. There were ambitious plans created from a foundation of local market analysis and an understanding of gaps or capacity shortfalls in local provision.

The business objectives for 2021 included developing the service and working towards accreditation with the Joint Advisory Group for gastrointestinal endoscopy. The accreditation process had already begun.

For our detailed findings on Vision & strategy, please see under this sub-heading in the surgery report.

Culture

Staff felt respected, supported and valued. The service had an open culture where staff could raise concerns.

Staff were open and friendly and spoke positively about working in the clinic. They gave examples of where they had been supported and how they offered support to colleagues. We saw warm, professional relationships between staff of all grades. We observed positive working relationships between staff. Due to the small size of the clinic, everyone knew each other, and we observed friendly interactions between staff. Staff told us they enjoyed working together.

There had been programme of cultural improvement led by the head of people, culture and talent. The ambient culture was built on shared corporate values and behaviours and known civic responsibilities. The cultural tone and behaviours had been devised in consultation with staff from all disciplines through direct discussions and surveys. It was embedded and used through the recruitment, induction and appraisal systems where staff were required to bring examples of where and how they had shown they were aligned with the values.

Staff were recognised and praised for their commitment to the role. A system of greeting cards had been commissioned that saw every new staff member receive cards from their team prior to starting, at specific points throughout their career and for any significant personal events or achievements.

Good

Medical care (Including older people's care)

There was an emphasis on the safety and wellbeing of staff. During the COVID-19 staff had completed a risk assessment to establish whether they were at increased risk of the virus. Staff completed lateral flow tests prior to each shift. Staff who tested positive for COVID-19 were asked to isolate and not to attend work. Staff who were clinically extremely vulnerable were supported to work in ways that maintained their safety reducing the risk of contracting the virus at work.

There was a very strong emphasis on equality and diversity within the service and staff felt they were treated equitably. The organisational culture was to welcome and celebrate diversity amongst the workforce and to use that diversity to improve the patient experience.

Staff told us they also felt part of the wider hospital team and were comfortable speaking with other staff members. We noticed several groups of staff of differing grades and professional disciplines enjoying breaks together.

For our detailed findings on Culture, please see under this sub-heading in the surgery report.

Governance

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

There were governance structures that included assessment of user satisfaction and complaints, audit of quality management systems and quality improvement. There was a system to ensure policies and procedures were kept up to date and in line with current guidance. For example, staff were aware of new anaphylaxis guidance issued the week before. The director of governance showed us they had received the new guidance, realised that this needed action to ensure ongoing compliance and had booked time to discuss the changes with all involved parties).

The governance processes allowed for challenge and innovation. There was comprehensive use of data to monitor performance quality and capacity. Data was also used to ensure that any under performance by individuals was addressed effectively and fairly.

The registered manager was very well informed about performance data. He could demonstrate compliance with the relevant legislation and high performance against national benchmarks and best practice guidance.

All levels of governance and management functioned effectively and interacted with each other appropriately. There was a structured approach to the running and safety of the clinics, with formal check in and sign out at the end of each session.

There were clear lines of accountability and staff knew who to report to. We saw management of equipment was systematic and staff knew who to go to if they encountered any problems. We saw records of equipment checks which took place at the beginning of each day.

The provider had current indemnity and public liability insurance and ensured consultants with practising privileges had appropriate levels in professional indemnity insurance.

For our detailed findings on Governance, please see under this sub-heading in the surgery report.

Managing risks, issues and performance

Good

Medical care (Including older people's care)

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.

There was a risk register and staff used an electronic reporting system to record new risks. Changes had been made in response to risk. Senior staff were able to talk to us about risks and what action had been taken or was being taken to address them.

There was a systematic programme of clinical and internal audit to monitor quality and operational processes, and systems to identify where action should be taken. We saw audits were a regular discussion point on the staff meeting minutes and several audits that had completed more than one cycle showed improvements. An internal audit had highlighted poor clinical performance in one case leading to suspension of practicing privileges.

There was a policy to ensure compliance to Data Protection Act 2018 and the General Data Protection Regulations.

For our detailed findings on Managing risks, issues and performance please see this subheading in the surgery report.

Managing Information

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

Staff demonstrated how easy it was to interrogate the system and could present this in several formats to help with understanding and analysis of the clinic's day to day running.

The registered manager had a very good grasp of how well the service was performing and could provide documentary evidence and data to show a positive culture and high performance.

The service had established electronic information systems and were able to show that all their systems were password protected.

The provider had effective arrangements to ensure the confidentiality of electronic patient information. Staff had access to a General Data Protection Regulation policy. Computer terminals were locked when not in use to prevent unauthorised persons from accessing confidential information. There was no evidence of patient identifiable information being accessible to those not providing direct care or treatment. Paper records were stored securely throughout the premises.

For our detailed findings on Managing information please see this subheading in the surgery report.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services.

Staff meetings were inclusive. They followed a standard agenda and staff were able to contribute even if they were unable to attend by submitting emails or asking the manager to raise a topic.

The provider supported and encouraged staff to participate in local charity endeavours. During the height of the pandemic staff were encouraged to support a local hospice to enable them to continue to deliver services.

There was a patient user group that met quarterly to discuss changes to the service and make recommendations. For example, the group had reviewed the patient information leaflets.

The provider worked through formal agreements with both a local NHS trust and the lead CCG to deliver services to support the local healthcare economy and reduce waiting times for diagnostic endoscopy procedures.

There was a regular staff survey which invited staff to give feedback about working at the hospital. Recent results were overwhelmingly positive.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation.

Staff were committed to continually learning and improving services. Staff were involved in the quality improvement plan and invited to make suggestions and give their views on development of the endoscopy service.

There was culture of progress embedded in the leadership team. They demonstrated a commitment to ensure the clinic had up to date technology and systems to aid the staff and ensure safety.

Resourcing was very generous which allowed staff time for learning, engagement and innovation. There were plentiful learning opportunities available to all as well as funding for external training through a fair application process. Staff development was very much encouraged.

The provider had funded a Graduate Management Training Programme that was in the midst of appointing trainees at the time of the inspection. The scheme would allow local young people opportunity to build experience in several areas of hospital delivery and management over a two-year funded course.

Good

Outpatients

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

Are Outpatients safe?

Good

Safe had not been rated previously. It was inspected and rated in 2016 but was then under different ownership. We rated it as good.

Mandatory training

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

The New Foscote Hospital had a mandatory training matrix which defined the mandatory training requirements of staff including bank workers and others who work at but are not employed directly by the hospital. Mandatory training was split into departments and job roles. Staff working in the outpatient department would have a personalised list of mandatory training for them to complete.

We assessed the mandatory training requirements and found the matrix was comprehensive and met the needs of patients and staff.

Staff we spoke with told us there were no barriers to accessing mandatory training.

Staff could check when any training was due. In addition, managers and the Head of People, Culture and Talent, monitored the matrix and alerted staff when they needed to update their training.

We looked at the completion rates of staff working in the outpatient department and diagnostic imaging service and were assured staff were completing their mandatory training. In addition, senior staff through conversation with the inspection team could demonstrate that they reviewed and had oversight of the team's mandatory training completion rates.

For our detailed findings on Mandatory training, please see under this sub-heading in the surgery report.

Safeguarding

Good

Outpatients

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

The New Foscote Hospital had a safeguarding children and adult policy (dated June 2020, review date June 2022) to guide staff when dealing with adults and/or children where abuse was either identified or suspected.

The director of nursing was the adult and child safeguarding lead for the service and had completed level 3 adult and child safeguarding training. They could demonstrate knowledge of the correct way to report an adult or child safeguarding concern.

We saw evidence staff working in the outpatient department had received safeguarding training specific for their role and knew how to recognise and report abuse. Female genital mutilation (FGM) was included in the safeguarding training and staff were aware of their responsibilities if they identified a patient whom had undergone FGM.

The diagnostic imaging manager who was the lead for all the allied healthcare professionals was trained to level 3 in adult safeguarding and child protection.

Consultants working in the outpatient department had to submit evidence they had completed their mandatory safeguarding training in their substantive post for their practising privileges to be renewed.

Staff could demonstrate how to make a safeguarding referral and who to inform if they had concerns. They gave us examples of when they had needed to do this.

The Hospital had a Provision of Chaperones during Examinations policy which was approved in March 2020 for two years. Staff working in the outpatient department and those running the ultrasound clinics routinely chaperoned patients when required and were aware of their responsibilities whilst doing so. During the inspection we saw signs offering chaperoning services to patients and observed the healthcare assistants chaperone patients during their appointments.

For our detailed findings on Safeguarding, please see under this sub-heading in the surgery report.

Cleanliness, infection control and hygiene

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

The New Foscote Hospital had infection control policies to help control infection risk. In addition, new protocols and procedures had been produced in response to the COVID-19 pandemic. This included a new procedure for when staff, patients and visitors arrived at the hospital. Different entrances were in use to access different areas of the hospital. This was done to limit the amount of people in one area and hence limit the risk of cross infection. COVID-19 checks were carried out in each area.

All hospital staff completed infection prevention and control (IPC) training as part of their mandatory training including a separate practical course on hand hygiene for relevant staff. The director of nursing was the infection control lead at the hospital.

Good

Outpatients

COVID-19 was still a risk when the inspection took place and therefore COVID-19 measures were in place at the hospital. During our inspection we saw the following COVID-19 measures carried out to protect patients, visitors and staff in the outpatient and radiology departments:

- Temperature checks at the entrance.
- Face masks available at the entrance.
- Hand wash basin at the entrance with hand sanitiser available throughout the departments.
- Well-spaced seating in the waiting area with laminated signs indicating which seats were clean and available for use and requiring a wipe clean.
- Signs to remind patients, visitors and staff of the need for social distancing to reduce the spread of the virus.
- Posters highlighting the importance of good hand hygiene.

We observed staff following good infection control practices to minimise the spread of any infection; they wore face masks, were 'bare below the elbow' and cleaned their hands before and after contact with every patient. Gloves and aprons were readily available for staff to use when required.

We saw that people maintained social distancing and seats were cleaned immediately after use by a member of the housekeeping or outpatient team. Appointments had a 5-minute gap to allow for rooms to be cleaned before the next patient entered. We also saw staff cleaned items such as pens, clip boards and debit card machines after patient use. Staff assured us that this was now part of their usual daily routine.

Staff could explain the procedures they would follow if they had concerns about a patient or visitor's infection status and gave us examples of when they had needed to do this.

Throughout the areas we visited hand sanitiser gel was available and we saw that staff and patients used it.

Clinical areas, consulting rooms, store cupboards and waiting areas including the toilets were visibly clean and tidy.

Consulting rooms were well ventilated with windows that could be partially opened to allow a flow of fresh air. This was supplemented by mobile air conditioning units and high-quality cooling fans.

We saw staff following the hospital IPC practices such as the correct usage of sharps bins and disposable curtains. Staff completed daily cleaning routines and recorded these when they were done. We reviewed these records during the inspection and found them to be mostly up-to-date and complete.

However, there were boxes containing engineer's manuals on the floor in the x-ray room control area which prevented thorough cleaning of the floor. Foam pads used for patient positioning during imaging procedures were not covered with a wipe clean material which presented an increased risk of cross infection.

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.

Good

Outpatients

The outpatient and imaging areas were accessed via the main reception. After completing the COVID-19 checks patients checked in at the reception desk. Plastic screens had been added to the front desk to provide a physical barrier between staff and patients as social distancing was not always possible. The screens helped reduce the potential risk of transmission of the COVID-19 virus.

The waiting area for outpatient and imagining rooms was spacious. Chairs and sofas were available to meet patient's needs. Due to COVID-19 precautions, the drinks machine was not operational but there was a fridge with bottled water available to patients.

The outpatient department was suitable for the services offered. There were four main consulting rooms that were spacious and airy, a minor procedures room with overhead lighting, clean and dirty areas, stock cupboards and a trolley for nursing staff to lay out equipment required for planned procedures and consultations and a large room used by the physiotherapy team with two entrances. This room could be split in two by a partition if needed with each area having its own entrance.

The outpatient department had storage cupboards for keeping patient records and paperwork. These cupboards were kept locked which meant access to these areas was controlled.

The diagnostic imaging department consisted of one x-ray room with appropriate radiation warning signs and one room used for ultrasound scanning.

There were emergency call bells in the main reception area, consulting and treatment rooms, the x-ray room and the toilets. This meant if staff or patients needed assistance there was a way to summon help.

We reviewed risk assessment documentation for the imaging service equipment and rooms and found it covered the safety issues for staff patients and escorts. Controlled radiation areas were clearly indicated with signs and warning lights above the doors.

The hospital maintained a central medical equipment register. This had details of all medical equipment used in the hospital and when it required servicing and electrical testing. During the inspection all equipment looked at in the outpatient department was stored neatly, was clean, dust-free and had the required up-to-date checks.

There was a medical physics expert (MPE) and radiation protection advisor (RPA) appointed to support the imaging service and we saw that service checks on the imaging equipment was completed annually, or when required according to manufacturer's recommendations. The radiology and allied health professional's manager was also the radiation protection supervisor (RPS) for the area. Fault logs and equipment handover sheets were available for us to see during our inspection. Staff explained that the MPE/RPA was based in Liverpool and was easily accessible on the telephone when they needed any support.

There was a cloud-based picture archiving and communication (PACS) system which meant that radiologists were able to access images for reviewing and reporting purposes from anywhere. Staff told us the radiology information system (RIS) was due to be upgraded as currently the system could not record a patient's radiation dose directly into their imaging record.

The service monitored staff for radiation exposure and consultant radiologists with practicing privileges were monitored at their NHS workplace. Consultants were notified if their monitoring devices recorded a reading above the acceptable threshold, however organisations did not share monitoring records.

Consumables were stored neatly in trolleys in the consulting and treatment rooms. Consumables we checked in the outpatient department were in date. However, sterile dressings and eye pads found in the cupboard in the X-ray room were more than a year out of date.

Staff told us there were no barriers to getting the right equipment and necessary consumables needed to provide safe and effective care and treatment to patients.

The emergency resuscitation trolley to be used in the event of a cardiac arrest was kept in the ward area of the hospital which was close to the outpatient area. The outpatient department had its' own resuscitation grab bag, kept at reception, and an automated external defibrillator in the corridor. Staff carried out daily and weekly checks to make sure equipment was available and operational if needed.

However, when we checked the anaphylaxis kit in the radiology department, we found a number of medicines held together in an unsealed blister pack. By storing medicines in this way made it difficult to know if the pack had been tampered with, and if the correct medicines were available in an emergency situation.

Clinical and domestic waste was disposed of separately in the correct colour coded waste bags. We observed staff disposing of waste in the appropriate bins.

All the sharps bins inspected were properly assembled, labelled and signed and dated in line with best practice and filled below the line indicated on the bin.

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.

There was a hospital daily huddle which was attended by a representative from all the hospital departments. This meeting was held at 9am every morning and all aspects of the hospital's business for the day was discussed. This included hospital activity, any patient concerns and staffing levels. We attended the daily huddle during our inspection and noted outpatient activity was discussed.

Staff knew in advance which patients were attending clinics that day. Patients requiring additional assistance or support were highlighted on the daily list of attendance and measures put in place accordingly. For example, if they needed an interrupter if English was not their first language.

On arrival at the hospital patients completed the COVID-19 checks and confirmed they were not presenting with any of the COVID-19 symptoms as described by the World Health Organisation (WHO). These checks were taken to help reduce the likelihood of patients bringing the COVID-19 virus into the hospital.

New and returning patients were given a questionnaire at reception to check their personal details, for example, name, date of birth and address and to fill out a health questionnaire. This made sure the hospital had up-to-date patient information.

Wherever patients sat in the waiting room they could be seen by the reception and outpatient team. This meant if a patient became unwell whilst waiting for their appointment a member of staff would be able to see them.

Good

Outpatients

Generally, acutely unwell patients would not visit the outpatient department. However, staff were trained in what to do if someone became unwell and deteriorated and who to escalate to if this should happen. Staff gave us examples where they had needed to alert a member of the clinical team or call for the crash team.

All results of blood tests taken in the outpatient department were reviewed by the resident medical officer (RMO) when received. This meant if there were concerns, they could be immediately flagged to the patient's consultant and the appropriate action taken.

In the x-ray room, we saw a poster which reminded the staff to check three points of patient identification before any exposure to radiation and use the Society of Radiographers "pause and check" which is an Ionising Radiation (Medical Exposure) Regulations [IR(ME)R] checklist for referring a patient for a diagnostic imaging examination. When followed it ensured the correct patient received the correct exposure to the correct anatomical area.

The hospital had an employer's procedures under IR(ME)R document which included a 'Procedure For Making Enquiries Of Females Of Childbearing Age To Establish Whether The Individual Is or May Be Pregnant Or Breastfeeding'; and we saw posters displayed requesting patients to tell staff if there was a possibility that they may be pregnant. This was to ensure that risks of radiation exposure to a foetus was minimal and patients who were potentially pregnant were informed of the risk from radiation exposure.

The imaging service local rules (IRR) and employers procedures (IR(ME)R) which protect staff and patients from ionising radiation were available for us to see during our inspection and the local rules were displayed in the x- ray room, signed and dated as read by the relevant staff.

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.

There are no agreed national guidelines as to what constitutes 'safe' nurse staffing levels in outpatient departments.

Staffing levels and skill mix for each day were planned by the matron and patient pathway manager and based on the type and number of clinics running and the number of patients attending.

Clinical services in the outpatient department were mainly provided by the outpatient healthcare assistants. Depending on the type and number of clinics running extra support was available from the ward registered nurses and healthcare assistants and they would be rostered on accordingly.

Staff we spoke with said the system worked well and there was always appropriate staff with the right skill mix to cover clinics. This was confirmed during our observations in the outpatient department.

There were sufficient staff numbers in the physiotherapy department to cover both the outpatient and inpatient aspect of their service.

If needed, the hospitals administration team were available to support outpatient staff on the reception desk.

Good

Outpatients

Staffing for the imaging department consisted of one full time radiographer and a regular bank radiographer which was sufficient for the workload at the time of our inspection.

The outpatient department had access to a range of medical consultants, who were granted practising privileges to provide an outpatient service at the hospital. Practicing privileges is a system of checks and agreements whereby doctors can practice in independent hospitals without being directly employed by them.

There was a resident medical officer (RMO) on-site 24 hours a day/ seven days a week. They provided medical care to patients at the hospital during the day and out-of-hours.

For our detailed findings on Staffing, please see under this sub-heading in the surgery report.

Records

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

Patient records were held securely onsite in locked cupboards.

Patients seen solely in the outpatient department and not admitted to the hospital had a set of records held by the relevant clinician and a duplicate set of records held by the hospital. The physiotherapy team had their own outpatient treatment card for each patient.

Records for clinics were made up in advance with clinic lists printed and cross checked to ensure the correct records were available. Labels for the outpatient notes were not printed until the patient arrived at the hospital and had confirmed their details were current and correct. This practice was carried out to avoid patient detail error on records. During the inspection we saw this process taking place.

There was a safe system for the transportation and management of records which we observed during the inspection. Patient records for the day were stored in a cupboard under the reception desk. The cupboard was unlocked when reception was manned but locked when necessary. When a clinic was running patients' records were placed on a designated area on the reception desk for the consultant to pick up when he collected the patient from reception. The records were in folders with the labels facing down so patient information could not be viewed by others. We were told the reception was constantly manned when clinics were running and this was observed during the inspection. Therefore, patient records were not left unattended.

Patient records contained all relevant information, patient details, including interventions to be completed at initial visits and follow ups; patient history, medicines, assessments and tests carried out, diagnosis and treatment plan. The allergy status of all patients was also recorded. Records reviewed during the inspection were accurate, comprehensive and provided a clear picture of the care and treatment each patient received from their initial contact through to discharge.

The imaging service radiology information (RIS) and picture archiving and communication system (PACS) were secure and password protected.

We saw examples of imaging requests which were appropriate and included the relevant information to allow for requests to be justified in accordance with IR(ME)R. Inappropriate requests were rejected, for example, an occasion when a referral for an x-ray was made when an ultrasound scan was more appropriate.

There was a list of medical referrers available to radiography staff; at the time of the inspection there were no non-medical referrers to the imaging service. Staff told us that GP referrers were checked against the medical register to ensure they were qualified under IR(ME)R to justify a radiation exposure.

For our detailed findings on Records, please see under this sub-heading in the surgery report.

Medicines

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

The New Foscote Hospital had a management of medicines policy (dated June 2020, review date May 2022) which provided the underlying principles associated with the management of medicines at the New Foscote Hospital and guidance for clinical staff around safe practice related to medicine.

Medicines used at the hospital were stored in the ward area of the hospital. The hospital did not have a medicine dispensing facility. When required consultants would write private prescriptions for patients to take to their preferred community pharmacy for dispensing.

Medicines required for outpatient clinics had to be ordered and stored in the ward medicine storage area. Records of medicines administered within the outpatient department had to be documented by the prescriber administering them. The record had to contain patient identification details, medicine name and strengths, route of administration, date and signature of the prescriber and person administering the medicine. These records had to remain on the hospital premises or be easily accessible should they need to be retrieved.

For our detailed findings on Medicines, please see under this sub-heading in the surgery report.

Incidents

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

Staff reported incidents using the hospital's electronic reporting system. The hospital provided mandatory training on how to use the system, with staff in the outpatient department service having 100% compliance with this training. Staff said they felt confident to report incidents and knew what constituted as an incident.

Post inspection we were told from June 2020 to May 2021 there had been no incidents reported relating to the outpatient department. However, during the inspection we were made aware of errors with patient details on records and a patient fall. Staff could explain what measures had been put in place to mitigate the incident happening again. Therefore, although we had evidence incidents were acted upon, we were unsure if these incidents had been recorded appropriately.

Good

Outpatients

The director of governance was a medical physics expert, therefore in a position to support the radiography team with regard to radiation incidents. The service had not reported any incidents during the 6 months from January 2021 to June 2021. However, the staff were aware of the requirement to report incidents of over exposure or incorrect radiation exposure to the IR(ME)R CQC.

During the inspection, we were made aware of incidents of inappropriate referrals for imaging. However, none of these were logged in the hospital incident management system.

Incidents were independently analysed by the director of governance and if required, a root cause analysis carried out. Outcomes were shared with individuals, department teams and the wider hospital if appropriate. Staff gave us examples of when this had happened and the change which occurred as a result of the incident. For example, asking patients to check their details prior to labels being attached to the outpatient notes, after the wrong details were found on notes.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.

Duty of candour was part of the hospital's mandatory training and staff we spoke with understood their responsibility to be open and honest with the patient when something had gone wrong. It was the responsibility of the clinical governance team to ensure the principles of the duty of candour had been completed. We were not told of any incidents in the outpatient or radiology department where the duty of candour had been applied.

The Clinical Governance team subscribed to all relevant patient safety alerts from external sources and we saw evidence that action was taken when needed.

For our detailed findings on Incidents, please see under this sub-heading in the surgery report.

Are Outpatients effective?

Inspected but not rated

At present we do not rate effectiveness for outpatient departments in acute independent hospitals but during our inspection we noted the following.

Evidence-based care and treatment

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

Clinical guidelines and policies were developed and reviewed in line with National Institute for Health and Care Excellence (NICE), the Royal Colleges and other relevant bodies. Policies and protocols were available on the hospital's intranet.

Good

Outpatients

The clinical governance team constantly monitored the NICE website and other relevant bodies for updates in guidance. This team, with the appropriate clinical leads, would then complete a gap analysis of their service compared to the new NICE guidance and incorporate the necessary changes into their working practices.

The hospital had a clinical and non-clinical audit programme which the outpatient and radiology departments took part in. The audit programme included general audits in documentation and infection prevention and control and more specific departmental audits such as image quality and rejected image in the radiology department. The radiology department also carried out audits required under IR(ME)R which included eight elements such as; 'has the correct area been imaged?' and 'Was the accumulative patient dose within national guidelines if applicable'. We saw results of the February 2021 IR(ME)R audit and could see staff were 100% compliant. All audits carried out in the department were used to identify issues and monitor improvements in the delivery of the service to the hospital's patients.

For our detailed findings on Evidence-based care, please see under this sub-heading in the surgery report.

Pain relief

When required staff assessed and monitored patients to see if they were in pain and gave pain relief in a timely way.

Patients were not routinely assessed for pain in the outpatient departments as this was not generally a clinical risk. However, if needed, pain would be discussed by the consultant as part of the presenting condition and captured in the patient notes accordingly.

The hospital's resident medical officers were used to assess patients and prescribe pain relief in cases requiring urgent attention.

The physiotherapy team monitored pain levels as part of their consultations and we saw this documented on the patient records using a visual analogue scale, 0 being no pain and 10 being severe pain.

Patient outcomes

There was limited monitoring of the effectiveness of care and treatment in the outpatient department.

The outpatient department did not specifically monitor patient outcomes. However, information collected by clinical audits and patient feedback were used within the outpatient department to improve care and treatment.

The physiotherapy team routinely monitored patient outcome measures such as range of movement, pain scores and quality of life measures. This information was collected for all patients at the start and end of treatment. The data obtained was reviewed as part the departmental review of the service and demonstrated the effectiveness of physiotherapy treatment for their patients.

For our detailed findings on Patient outcomes, please see under this sub-heading in the surgery report.

Competent staff

Good

Outpatients

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

The trust had a well-planned induction programme for newly appointed staff. This was a set programme for staff to orientate themselves with the hospital, their department, the expected behaviours and training in procedures and policies. This was tailored to the individual's role at the hospital.

We saw that nurses, healthcare assistants and allied health professionals completed competency frameworks to ensure they were competent to carry out their role. There were general competencies and competencies specific to the medical speciality they were working in. We were told about extended competencies in the outpatient department with the healthcare assistants gaining additional competencies in phlebotomy and for taking electrocardiograms (ECGs).

The equipment training records in radiology showed that all the relevant staff were competent to use the equipment available to them. Staff told us that they had already been offered applications training for new equipment planned for delivery later in 2021.

Staff we spoke with confirmed they were encouraged to undertake continual professional development and were given the opportunity to develop their skills and knowledge through training relevant to their roles. For example, training in shockwave therapy in the physiotherapy department and cross department working for the healthcare assistants.

Staff we spoke with had yearly appraisals with their managers. The appraisal was designed to provide both the member of staff and their line manager with feedback on their performance and identify any areas which may require improvement. All staff working in the outpatient department had been appraised in the last year with staff finding them useful and worthwhile.

For our detailed findings on Competent staff, please see under this sub-heading in the surgery report.

Multidisciplinary working

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

There was a hospital daily huddle which was attended by a representative from all the hospital departments. This meeting was held at 9am every morning and all aspects of the hospitals business for the day was discussed. This included hospital activity, any patient concerns, staffing levels and if any team needed support from the wider hospital. We attended the daily huddle during our inspection and noted a supportive culture within the hospital.

During the inspection we observed good multidisciplinary working across the outpatient department. For example, ward staff supporting the outpatient team during busy times and members of the administration team covering breaks on the reception desk. The physiotherapy team explained how they interacted with all teams at the New Foscote Hospital to effectively carry out their role.

We observed a strong working relationship between the consultants and outpatient staff. There was equal respect for the other's role and the understanding that working together in a collaborative way improved the patient's experience within the department.

Good

Outpatients

Staff could explain how good multidisciplinary working in outpatients enabled efficient delivery of care to patients by limiting the number of times they needed to attend clinics. For example, patients requiring a blood test or scan were seen on the same day as their outpatient appointment when possible.

For more detailed information on Multidisciplinary working please see the surgery report.

Seven-day services

The outpatient department including the physiotherapy and radiology teams did not provide urgent or acute services and therefore were not available seven days a week. Clinics operated between 8am and 8pm Monday to Friday. However, some consultant and physiotherapy clinics ran on Saturday mornings.

For our detailed findings on Seven-day services, please see under this sub-heading in the surgery report.

Health promotion

COVID-19 was still a risk when the inspection took place and therefore COVID-19 measures were in place at the hospital. This included, as a preventative measure, limiting the number of objects in communal areas, such as patient information leaflets. However, leaflets were available via the outpatient staff, consultants and physiotherapy team.

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

Staff in outpatients would assess each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle. Depending on the issue, patients would be offered advice and signposted to the relevant organisations or to their GP.

The New Foscote Hospital website offered insights into various topics. At the time of the inspection there was information on total hip and total knee replacement physiotherapy and World kidney Day, a global campaign to raise awareness of the importance of our kidneys to overall health.

For our detailed findings on Health promotion, please see under this sub-heading in the surgery report.

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. They used agreed personalised measures that limit patients' liberty.

COVID-19 was still a risk when the inspection took place. Therefore, COVID-19 measures were in place at the hospital. This included a symptom declaration and consent forms patients completed prior to visiting the outpatient clinics.

Good

Outpatients

Staff had a good understanding of the consent procedure. They knew consent was gained verbally prior to care or treatment being performed and for more complex procedures a completed and signed consent form would be necessary. There was good evidence of consent being sought and consent documentation used in the outpatient department.

We saw evidence that consent for surgical processes was obtained during outpatient appointments and prior to the operation. This gave patients time to have a thorough discussion with their consultant and time to think about their treatment options before the day of the surgery.

Mental capacity act (MCA) and deprivation of liberty safeguards (DoLS) training was part of the mandatory training for staff and staff were aware of their responsibilities. All outpatient staff were up-to-date with their MCA and DoLS training.

The patient's capacity was not formally assessed in clinics as all patients were assumed to have capacity. However, should staff have concerns about a patient's mental health or capacity to consent verbally to investigations they would discuss this with the patient's consultant or their line manager.

Are Outpatients caring?

Good

Caring had not been rated previously. It was inspected and rated in 2016 but was then under different ownership. We rated it as good.

Compassionate care

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

Staff throughout the outpatient department put patients at the centre of what they did. During the inspection we saw pleasant interactions between staff and patients. We saw staff treat patients with warmth and care, they were courteous, professional and demonstrated compassion to all patients.

Staff introduced themselves to patients and all staff wore name labels on their uniform which enabled patients to easily identify which staff member was providing their care/support.

Patients were treated with dignity and respect at all times. Clinic rooms had 'vacant/engaged' signs on the doors and we observed staff knocking and waiting before entering clinic rooms. We saw reception staff being discreet with their interactions with patients and their computer screens had privacy filters which limited the angle of vision to a front view so others in the room could not casually see the display and any information showed.

Feedback from patients, both verbal and through patient surveys, was positive.

Emotional support

Staff provided emotional support to patients.

Good

Outpatients

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

Outpatient staff told us they sometimes saw patients who appeared anxious due to the nature of their visits. They understood the need to give patients appropriate and timely support and information to cope emotionally with their care, treatment or condition.

We observed staff routinely speaking with patients in the waiting area to make sure they were comfortable and to help with any concerns they had.

We were told if a patient became distressed in the open environment, they could be taken to a spare room if available, to help maintain their privacy and dignity. Staff told us upsetting or unexpected news was delivered sensitively and in appropriate private surroundings.

Understanding and involvement of patients and those close to them

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

We heard and saw through patient feedback that patients felt actively involved about their care. They said staff explained procedures and obtained their consent before any treatment and this was documented in patient's notes.

Patients said consultants were thorough, spent time explaining procedures to them and they felt comfortable and reassured. Patients told us they did not feel rushed during their appointments and that they had the opportunity to ask questions. They felt they were given clear and adequate information. Physiotherapy patients were given a longer initial consultation to ensure they had time to ask questions following their assessment.

Patients knew how and who to contact if they had concerns after their appointment and were aware of how to book their next appointment date if needed.

Are Outpatients responsive?

Good

Responsive had not been rated previously. It was inspected and rated in 2016 but was then under different ownership. We rated it as good.

Service delivery to meet the needs of local people

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

Good

Outpatients

The majority of patients who attended the New Foscote Hospital were privately funded or had insurance cover for planned procedures. However, the hospital also worked with local commissioning groups to provide and treat NHS patients with a number of specific procedures. The hospital used the NHS e-referral service for these procedures which meant that patients and GPs could book services directly.

The hospital's website listed the treatments and services available to patients and gave details on how to contact the hospital to discuss services offered.

The hospital's booking team who were responsible for booking all new outpatient appointments were available 6 days a week, Monday to Saturday. The extended opening hours were to ensure patients had the ability to book appointments at a time that suited them.

Staff told us that patients were usually seen promptly following their referral. Patients were given the next available appointment with their chosen consultant. Patients confirmed they had not waited long for their outpatient appointment.

We observed a relaxed atmosphere in the outpatient area. The waiting areas were not overcrowded and clinics were running on time. Clinics ran in the outpatient department between 8am and 8pm Monday to Friday, and on Saturdays until 1pm. This allowed patients who worked office hours during the week to attend clinics at a time that suited them. Patients told us they were able to get appointment times that suited their needs.

The outpatient department, where possible, minimised the number of times patients needed to attend the hospital by ensuring patients had access to the required staff and tests on one occasion. For example, patients requiring a blood test or scan were seen on the same day as their outpatient appointment.

For our detailed findings on Service delivery to meet the needs of local people, please see under this sub-heading in the surgery report.

Meeting people's individual needs

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

The hospital had admission criteria which meant that the hospital only admitted patients whom the hospital had facilities and expertise to care for.

Patient's individual needs were discussed during booking of appointments. The information was used by staff to provide care and treatment in a safe way and mitigate any possible risk to the patient. If staff identified the service could not meet the patient's needs, staff would not treat them at the hospital but refer them to an alternative health care provider who could better support the patient.

Staff knew in advance which patients were attending clinics that day. Patients requiring additional assistance or support were highlighted on the daily list of attendance and measures put in place accordingly.

Staff told us interpreting facilities were available to patients whose first language was not English. The need for interpreting services would be established at booking. Staff explained that patient's friends or family would not be used

to help translate. This is in line with best practice as interpretation undertaken by people involved with the patient may be distorted (due to over protectiveness, bias, conflicting interests or lack of understanding of clinical terminology) and may not be an appropriate way of communicating confidential information. Many of the hospital staff had existing foreign language skills and could be used as an interpreter. The languages spoken by staff was displayed in the outpatient department.

Information provided to the patient prior to their appointment both in a letter and on the hospital's website helped outpatient patients to prepare for their appointments. This included information on how to travel and park at the hospital and what to do on arrival at the hospital. The hospital had four electric charging bays, spaces for disabled patients and easy hospital access. There was ample parking on the day of inspection for all activities taking place at the hospital. Staff realised by providing information prior to appointments helped reduce patient's anxiety when attending their appointments.

For our detailed findings on Meeting people's individual needs, please see under this sub-heading in the surgery report.

Access and flow

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

Patients were referred to the outpatient's department by self-referring or by their GPs. Patients could book an appointment by contacting the patient pathway team. Patients were offered the most convenient appointment with their preferred consultant. None of the patients we spoke with or feedback we reviewed from patients had complained of long wait times for appointments.

Reception staff welcomed patients to the hospital, checked them in on the hospital computer system and told them where to wait for their appointment. On the day of the inspection patients were seen quickly following their arrival in the department.

If patients required a follow up appointment or to be booked in for tests, this was completed before they left the hospital by the reception staff.

There was no formal monitoring of wait times in the outpatient department. However, wait times was not highlighted as a problem in patient feedback forms.

On the day of the inspection the outpatient department was calm and smoothly run by a team who were confident, efficient and professional.

For our detailed findings on Access and flow, please see under this sub-heading in the surgery report.

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).

Good

Outpatients

Staff followed the New Foscote complaints policy when investigating and responding to complaints or concerns. The medical director had overall responsibility for the management of complaints.

We saw posters in the waiting area of the outpatient department which gave details on the hospital's complaint procedure and how to make a complaint.

Staff in the outpatient department told us they always tried to address complaints or concerns immediately to see if they could be solved straight away. If the problem could not be resolved by the team, staff told us patients were given details on how to make a complaint.

The hospital had a form where patients could give their feedback on the hospital and the care and treatment they had received. Responses from the feedback form were used by staff to make improvements to the hospital. We were given examples where changes had been made.

Post inspection we requested data on how many formal complaints the outpatient department had received in the last 12 months. Information supplied by the hospital post inspection confirmed the outpatient department had received seven complaints in the last 12 months with six being successfully resolved with the patient.

We saw evidence that hospital complaints, both formal and informal were discussed and addressed at the quality and risk meeting and in the medical advisory committee meeting. Any themes or trends to the complaints were analysed and actions put in place to stop them occurring again. For example, clearer information given to patients regarding equipment needed for their recovery.

Outpatient staff told us that feedback from complaints and concerns were discussed at the team meetings, during daily face to face catch ups and in handover sessions. Staff we spoke with could give us examples of learning from complaints and concerns and genuinely viewed these as an opportunity for improvement.

For our detailed findings on Learning from complaints and concerns, please see under this sub-heading in the surgery report.

Are Outpatients well-led?

Good

Well-led had not been rated previously. It was inspected and rated in 2016 but was then under different ownership. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were 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 lines of leadership and accountability. The outpatient department was led by the director of nursing – matron and supported by the patient pathway manager. The matron had clinical responsibility and managed the

registered nurses and the healthcare assistants. The patient pathway manager had responsibility for the non-clinical processes in the department and managed the administrators and patient pathway coordinators. The physiotherapy team worked closely with the ward & outpatient department and was line managed by the imaging & allied health services manager.

When we spoke to the managers, they had a good understanding of the challenges to quality and sustainability in each of their areas and were able to tell us the actions needed to address them. They told us they felt supported by other members of the senior management team and the medical director. They were able to discuss any issues with them, were listened to and their views respected.

Staff working in the outpatient department spoke highly about their managers and felt supported and valued. Managers were highly visible and approachable and we saw evidence of this on the inspection.

For our detailed findings on leadership, please see under this sub-heading in the surgery report.

Vision and strategy

The service had a vision for what it wanted to achieve and with workable plans to fulfil the vision. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The future vision for the outpatient department was to look at clinic utilisation and to increase the services offered to patients. To achieve this vision the outpatient department would require more space. Therefore, moving some specialist services to different locations was being considered.

The hospital was committed to building a dynamic clinical workforce that could be flexible and responsive to the demands of the hospital. This meant training all registered nurses, healthcare assistants and allied health professionals to cover both outpatients and the ward when needed. For example, there was no longer a dedicated pre-assessment team, all nursing staff had been given the appropriate training to carry out this service. Staff we spoke with understood the need to be more flexible and thought it was a positive change that improved their skills. It was understood by senior members of the outpatient team that training and support was essential to make staff feel comfortable working in unfamiliar areas. We saw evidence of this support during the inspection.

For our detailed findings on Vision & strategy, please see under this sub-heading in the surgery report.

Culture

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

Staff we spoke with felt supported, respected and valued in their working environments. Staff told us they felt supported as individuals in their roles but also as part of the wider hospital too.

Staff spoke positively and passionately about the care and the service they provided. Quality and patient experience were seen as a priority and responsibility for everyone.

Good

Outpatients

Staff were welcoming, helpful and professional in their communication with each other, patients and visitors. Staff described good teamwork and respect amongst their colleagues, and we could see this in practice when we inspected the outpatient department. It was also reflected in low vacancy, sickness and turnover rates in the outpatient department and wider hospital.

Since the change in ownership of the hospital, culture had been one of the main focus of the new management team. All staff had been involved in the creation of the organisation values and civic responsibilities for the hospital. These values were displayed in the outpatient department and staff told us they adhered to these principles.

The staff promoted equality and diversity in their daily work. For example, one of the rooms in the outpatient department had been converted into a prayer room for staff. The room was an area staff of any religion or no-religion could use as a quiet place for reflection if needed.

For our detailed findings on Culture, please see under this sub-heading in the surgery report.

Governance

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

The New Foscote Hospital had a governance framework through which the senior management team was accountable for continuously improving their clinical, staff, and financial performance. There was a meeting planner which listed the meetings that took place and their frequency. Most of the meetings followed a set agenda. The hospital sub-committees fed into the quality and risk, and the Medical Advisory Committees.

The quality and risk meeting looked at the key quality issues of safety, risk, clinical effectiveness and patient experience. It was up to the heads of departments to disseminate this information to their teams and to act on any issues arising.

There was no planned outpatient meeting. Post inspection we requested the minutes of the last three ward meetings, which according to the hospital meeting planner took place every two months, to see if the outpatient and physiotherapy departments were discussed at these meetings. From the evidence received there had not been a formal minuted ward meeting since 21 Sept 2020. Therefore, there was no evidence or assurance the outpatient or physiotherapy departments were discussed, actions taken in a timely way or staff in these areas were receiving information on key quality issues of, safety, risk, clinical effectiveness and patient experience. However, post inspection we were told nurses and healthcare assistants working at the New Foscote hospital met to discuss issues relating to their roles and departments. Prior to the meeting staff were able to add items to the agenda if they had issues they wanted to discuss. Post inspection we reviewed the minutes from this meeting and could see outpatients and physiotherapy were represented and it was a good way for clinical staff at the hospital to raise operational issues and to action changes. It also gave outpatient staff an understanding of other teams and their challenges. However, from the minutes it was unclear of the frequency of these meetings and if a senior manager attended to give approval to actions agreed.

Issues relating to the imaging service were discussed at a radiation safety committee meeting which took place twice a year and reported to the quality and risk committee. The radiation protection advisor (RPA) attended these meetings along with the radiation supervisor and service manager with senior management representation. We saw from minutes

of the meeting that the IRR17 & IRMER17 compliance audit and the RPA annual reports formed part of the agenda. We saw from the most recent reports that the staff had addressed non-compliance with the IRR17 regulations. The IR(ME)R compliance audit had taken place just before our visit therefore some areas of non or partial compliance were yet to be actioned.

Staff working in the outpatient department told us that information would be shared with them in many ways including, at handovers, emails, on notice boards, the staff newsletter and in meetings.

Staff undertook internal quality audits which assisted in driving improvement and gave all staff ownership of things that went well and that needed improvement. This ensured staff of all grades were involved in quality improvement in their department. During the inspection we were shown and discussed the cleaning audits that were used in the outpatient department.

For our detailed findings on Governance, please see under this sub-heading in the surgery report.

Managing risks, issues and performance

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

The New Foscote Hospital had a risk management and health and safety policy. This policy detailed the aim of risk management, explained what risk was and how to identify, record, review and mitigate risk.

There was a hospital risk register which we reviewed post inspection. At the time of inspection there was one risk on the register for the outpatient department, four for the physiology department and six for the imaging department.

We saw evidence risk management was a set agenda item on the quality and risk meeting agenda. We could see that risks were reviewed and there was a date of the last review and any actions taken. However, it was unclear if all aspects of the risk register were current and up to date. For example, risks allocated to the physiotherapy team, which were still ongoing according to the risk status on the register, had the responsible person for the risk as staff whom no longer worked at the hospital. The risk had not been reassigned or a comment made on the register to say who now owned the risk.

For our detailed findings on Managing risks, issues and performance please see this subheading in the surgery report.

Managing information

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

The hospital used computer toolkits and dashboards to collect and monitor data throughout the hospital including the outpatient department. Data on staffing, quality and safety was collected and reviewed.

Good

Outpatients

Since the change in ownership in 2019, there had been a review of how data was collected and the systems used to manage, store and monitor data. There had been investment in new systems, including the telephone system used.

Staff working in the outpatient department told us there had been big advances in how the hospital was using data to monitor quality and drive improvements, for example incident reporting and the audit program. They spoke highly of the hospital management team in the implementation of the new systems and the new ways of working. This had given the outpatient staff a greater understanding of why these systems were important and how it impacted on their patients and led to better outcomes.

For our detailed findings on Managing information please see this subheading in the surgery report.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

The New Foscote Hospital actively gathered patients' views and experiences through questionnaires to help develop hospital services. Patient comments were evaluated monthly, positive comments were shared with staff and negative comments discussed with the governance team, the department concerned and the wider hospital teams to decide what actions should be taken.

We reviewed patient survey results from September 2020 to May 2021 and could see the response rates ranged from 19% to 41% with an average of 28%. The feedback was mostly very positive. The physiotherapy team used their own patient feedback forms which were emailed to patients after treatment. Staff could tell us of changes that had been made to the outpatient department due to feedback from patients.

The hospital had a webpage where the public could access information about the hospital, including patient services, patient and visitor's information, how to contact the hospital and the latest hospital news.

The hospital also had a public presence on social media platforms. Information on hospital news, events and media stories were shared here.

The hospital produced a monthly magazine for staff that informed staff of the latest healthcare news, local information and staff stories. There was a yearly staff survey, which gave staff the opportunity to anonymously give their views on working at the hospital. Staff in the outpatient department had contributed to the latest survey run by the hospital.

Staff we spoke with felt management included them in hospital decisions and made them feel valued.

For our detailed findings on Engagement please see this subheading in the surgery report.

Learning, continuous improvement and innovation

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

Good

Outpatients

All staff involved with the outpatient and radiology departments were passionate about developing it and giving the best care and treatment possible to their patients. When issues arose, they worked with the hospital's management team to come up with solutions. During the inspection we were given examples where changes had been made to improve their services. For example, how to manage patient information to avoid errors on records and flexible staffing.

Staff were keen to learn and sought out learning opportunities, both internally and externally to increase their own skill set. We were given examples of training and courses staff had attended to aid their personal development, which in turn enhanced the services they could offer their patients.