Practice Plus Group Hospitals Limited

Practice Plus Group Hospital, Plymouth

Inspection report

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Date of inspection visit: 09 November, 10 and 22 November 2022 and 19 January 2023
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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 carried out a short announced comprehensive inspection of the services on 9 and 10 November with a further telephone interview on 22 November 2022. We completed a further follow up inspection on 19 January 2023.

Practice Plus Group Hospital, Plymouth is an independent hospital that employs around 160 staff and provides care to patients in the South West of England. The hospital provides the following services: surgery (predominantly knee and hip replacement), general surgery, outpatients and diagnostic imaging.

The service is registered with CQC to provide the following regulated activities:

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

At the time of inspection the hospital did not have a registered manager, the interim hospital director had made an application to be the registered manager and it was being considered. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The hospital was previously inspected on 13 and 14 July 2016 when the hospital was a different legal entity and managed by a different organisation. It was rated as outstanding overall with ratings of outstanding in caring and well led, alongside good in safe, effective and responsive. The previous rating included a joint rating for outpatients and diagnostic imaging service, we have rated them independently as part of this inspection.

Following this inspection our overall rating of this service was good. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff 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. People had instant access to translation services and interpreters were available by phone or video using a portable tablet device.

Summary of findings

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

However:

- Not all medicines were stored securely. Intravenous medicines on the surgical ward were not stored securely in accordance with national guidance.
- Not all staff were in date with their mandatory training. There was not an effective governance process and oversight of training performance.
- There was a reduced ophthalmology service due to staffing levels.
- We were told learning from incidents was discussed but this was not always documented within meeting minutes.
- In outpatients, staff did not routinely receive a daily brief with key information to keep patients safe.
- Some people had to wait a long time for treatment. The hospital was not meeting referral to treat times in line with national guidance but were working hard to reduce the waiting times for patients.
- The provider did not have a robust system to respond to concerns about a person's fitness to practice. Where a person's fitness to carry out their role was being investigated, appropriate interim measures were not taken to minimise any risk to people using the services. A risk assessment was not completed to evidence rationale, decisions and actions. Information was not shared with the location.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	We rated it as good because: • The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. • Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and had access to good information. Key services were available seven days a week when required. • Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. 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. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually. However: • Not all medicines were stored securely. Intravenous medicines on the surgical ward were not stored securely in accordance with national guidance.

Summary of findings

- Not all staff were compliant with life support training, and there were not effective systems to have oversight of staff training compliance.
- The provider did not have a robust system to respond to concerns about a person's fitness to practice. Where a person's fitness to carry out their role was being investigated, appropriate interim measures were not taken to minimise any risk to people using the services. A risk assessment was not completed to evidence rationale, decisions and actions. Information was not shared with the location.

Outpatients

Good

We rated this service as good because it was safe, caring and responsive and well led. We do not rate effective.
We rated it as good because:

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

Summary of findings

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

However:

- Some people had to wait a long time for treatment. The hospital was not meeting referral to treat times in line with national guidance but were working hard to reduce the waiting times for patients.
- There was a reduced ophthalmology service due to staffing levels.
- We were told learning from incidents was discussed but not always documented within meeting minutes.
- Not all staff were in date with their mandatory training.

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

Diagnostic and screening services

Good

We rated this service as good because it was safe, caring and responsive and well led. We do not rate effective.
We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had updated their training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. Managers monitored the effectiveness of the service and

Summary of findings

made sure staff were competent. Staff worked well together for the benefit of patients and had access to good information. Key services were available seven days a week when required.

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

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

Summary of findings

Contents

Summary of this inspection

Background to Practice Plus Group Hospital, Plymouth

Practice Plus Group Hospital, Plymouth is operated by Practice Plus Group Hospitals Limited. The hospital has 30 beds with 12 patient bays including four patient treatment chairs. There were three laminar flow theatres, one endoscopy theatre and one day case theatre. There was one post-anaesthetic care unit with five recovery bays. The hospital also has outpatient and diagnostic imaging departments.

Surgery was the main proportion of hospital activity. Where our findings on surgery, for example, management arrangements, also apply to other services, we do not repeat the information but cross-refer to the surgery service.

How we carried out this inspection

The inspection team consisted of 1 inspection manager, 3 inspectors and 2 specialist advisors with expertise in surgery and diagnostic radiography who carried out a site visit on 9 and 10 November 2022. We held a telephone call on 22 November 2022. We completed a further follow up inspection on 19 January 2023 with 1 inspection manager and 1 inspector.

The inspection was overseen by Catherine Campbell, Head of Hospital Inspection.

You can find further 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.

During the site visit we met and spoke with patients and staff. For surgery, we spoke with 10 patients and 12 staff and reviewed 8 patient records. For outpatients, we spoke with 7 patients and 7 members of staff. For diagnostic imaging we spoke with 6 members of staff and 6 patients. We spoke with 5 people from the senior management team, the HR regional manager, head of talent acquisition and resourcing, and the corporate Medical Director. We also reviewed 10 personnel files and attended the weekly scheduling meeting.

We looked at documentation and patient outcome data before, during and following the inspection.

Outstanding practice

We found the following outstanding practice:

- The service used a portable tablet device that could translate many different languages. There was instant access to over 200 interpreters who were available by phone or video and it also included British sign language which was available through a video link.
- The service used an innovative waste management system which collected, transported and disposed of hazardous fluid waste and surgical smoke during surgery. Surgical fluids were collected into a mobile suction unit and then automatically disposed of directly to the sluice drain via a docking station, saving on waste costs.

Summary of this inspection

Areas for improvement

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

Action the service MUST take to improve:

Surgery

- The service must ensure that intravenous medicines are stored securely in accordance with national guidance. (Regulation 12 (2) (g)).
- The provider must ensure they have robust systems to respond to concerns about a person's fitness to practice. Where a person's fitness to carry out their role is being investigated, appropriate interim measures must be taken to minimise any risk to people using the services. A risk assessment should be completed to evidence decisions and actions. (Regulation 19 (5))

Action the service SHOULD take to improve:

Overall

- The service should ensure staff mandatory training compliance is improved and there is an effective governance process and oversight of training performance. In particular, basic and immediate life support, mental capacity act and deprivation of liberty safeguard.
- The service should consider introducing training for staff around patients with mental health needs and violence and aggression as part of the mandatory training programme.
- The provider should continue to follow their policy for recruitment and ensure all evidence to meet Schedule 3 requirements is stored on electronic files.

Surgery

- The service should complete an action plan in response to their documentation audit, identifying areas which do not meet or partially meet standards and the actions taken to improve compliance, and evidence improvement through further audit.

Outpatients

- The service should ensure that they continue to actively try and recruit to fill the vacant posts within ophthalmology.
- The service should ensure work continues to reduce the referral to treat waiting times in line with national guidance.
- The service should consider minuting learning from incidents within department meetings.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Requires Improvement	Good
Outpatients	Good	Inspected but not rated	Good	Requires Improvement	Good	Good
Diagnostic and screening services	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	Requires Improvement

Are Surgery safe?

Good

We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff. However not all staff had completed it.

The mandatory training was provided and mostly met the needs of patients and staff. Training included how to recognise and respond to patients with mental health needs, learning disabilities, autism and dementia. Noticeboards provided information on training available.

Clinical staff completed training on recognising and responding to patients with learning disabilities, autism and dementia. The hospital had arranged dementia simulation training for staff. However, there was no evidence of training for recognising and responding to patients with mental health needs or violence and aggression. Following the inspection we were told many staff had undertaken conflict resolution training. Staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards, however, only 77% of surgery outpatient staff were in date for this training. There were 3 mental health first aiders.

Staff did not keep up to date with their mandatory life support training. Data provided to us following the inspection showed that 65% of staff had completed either basic or immediate life support training at the time of our inspection. We were told this was due to a recent change in the training booking process. Until September 2022, this training was facilitated by the local NHS trust who had cancelled some training sessions as a result of the Covid-19 pandemic. The service had recruited their own on-site trainer and planned to double this capacity in the early months of 2023.

Managers monitored overall mandatory training at monthly clinical governance meetings and noted low compliance, however, actions were not taken to improve this and was not recorded on any risk registers supplied to us.

Safeguarding

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

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

Staff received specific training on how to recognise and report abuse. The on-site nominated lead was trained to level 4 in safeguarding adults and children.

Staff gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. We reviewed their safeguarding policy which was in line with the latest legislation.

Staff received training specific for their role on how to recognise and report abuse. Most staff were up to date with safeguarding training at the time of inspection. Across all services, training compliance was 88% for safeguarding level 3 for adults and children.

Overall compliance with online adult safeguarding level 1 training was 89% and 80% for level 2. Overall compliance with online safeguarding training for children was 88% for level 1 and 86% for level 2.

Staff followed safe procedures for children visiting the ward.

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.

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

The service performed well for cleanliness. Cleaning audits for August, September and October 2022 showed 100% compliance with national standards. Weekly cleaning audits were completed in theatres, monthly in other areas. These were shared with the Infection, Prevention and Control (IPC) lead for the service. Any problems such as dust in corners or on vents were rectified immediately and shared with the team.

Staff used records to identify how well the service prevented infections. This was discussed at monthly clinical governance meetings and covered any infection, prevention and control concerns. Deep cleaning was completed on clinical governance days or bank holidays when theatre lists were not running. This was carried out by an external contractor. The next deep clean was booked for 14 January 2023. If an outbreak occurred or a patient had an infection, they would organise an urgent deep clean.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed consistent PPE compliance in theatres and on wards.

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

Staff worked effectively to prevent, identify and treat surgical site infections. Two dedicated cleaners were ward-based between 8am to 6pm each day. Cleaners were available for the wider site between 3am to 8am and theatre cleaners worked between 6pm to 9pm.

Changes to cleanliness processes and practices were implemented and communicated to staff verbally, during team meetings and by email.

Good

Surgery

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. We observed staff responding quickly to call bells when used by patients.

The design of the environment followed national guidance such as the relevant NHS England Health Building Note guidance which gives best practice guidance on design of healthcare buildings.

Staff carried out daily safety checks of specialist equipment, this included resuscitation trolleys and equipment required for surgery. Staff were encouraged to raise any faults. Engineers were introduced to carry out repairs, other improvements included recent replacement of boilers, fire alarm systems and fire doors.

The service had suitable facilities to meet the needs of patients' families. Managers said plans to redesign the car park were in progress and included provision for additional disabled car parking spaces.

The service had enough suitable equipment and personal protective equipment (PPE) to help them safely care for patients.

We reviewed information from the service about any recent Patient-Led Assessments of the Care Environment (PLACE) by NHS England following our inspection and found that the outcome was positive and recommendations were being addressed.

Staff disposed of clinical waste safely. Clinical waste was collected 5 days each week by an external contractor. There was an effective system for bagging and marking up clinical waste across the hospital. However, there was capacity for overflow and extra collections could be arranged with the external contractor if required.

Assessing and responding to patient risk

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

Staff used a National Early Warning Tool version 2 (NEWS2) to identify deteriorating patients and escalated them appropriately. We reviewed 8 completed NEWS2 checklists which confirmed that patients were closely monitored.

There was a policy for transfer of patients to the nearby NHS hospital trust for emergency treatment if required. Between December 2021 and October 2022, 16 patients, out of a total of 6,180, were transferred to the local hospital trust for emergency treatment as a result of unexpected post-surgical complications. The service analysed each case to identify any potential improvements.

We observed several procedures with full completion of the World Health Organisation (WHO) surgical safety checklist by theatre staff. Following our inspection, we requested WHO checklist audit data from November 2021 to October 2022. We received information which showed 100% compliance in December 2021 and July 2022 alongside an action plan following an audit in March 2022 with several actions identified. We did not receive the information for the missing monthly checks as requested. However, we were provided with a compliance check of 96.67% that was completed a few days after our inspection.

Good

Surgery

Staff completed risk assessments for each patient upon admission using a recognised tool. Staff were aware of risks including sepsis and action to take, patient records included a sepsis checklist and we reviewed the policy for this following our inspection.

Staff knew about and dealt with any specific risk issues. The service held weekly scheduling meetings to discuss each patient and their individual needs around 3 weeks before their surgery was due. We reviewed their exclusion policy which included children and pregnant women. Patient records included checklists for potential risks such as sepsis, venous thromboembolism, falls and pressure ulcers.

The service had 24-hour access to mental health liaison and specialist mental health support from the local NHS hospital, although they did not usually treat patients who were detained under the Mental Health Act.

Staff shared key information to keep patients safe when handing over their care to others. Staff completed discharge summaries to referring clinicians and provided families with verbal and written aftercare information.

Shift changes and handovers included all necessary key information to keep patients safe. We observed handovers which included inclusive discussions about patients, their treatment and discharge plans.

Nurse Staffing

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

The service had enough nursing and support staff to keep patients safe. The number of nurses and healthcare assistants for shifts we reviewed matched the planned numbers. Nurse staffing was closely monitored on their risk register.

During weekly scheduling meetings, managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. They adjusted staffing levels daily according to the needs of patients. Cover was provided for staff absence and managers requested bank and agency staff who were familiar with the service. They made sure all bank and agency staff had a full induction.

A new cohort of assistant practitioner courses for healthcare assistants (HCAs) had started and there were plans to consider starting a similar course for theatre HCAs to allow them to train as scrub practitioners.

Medical Staffing

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

The service had enough medical staff to keep patients safe. Consultants were recruited following NHS employment standards and were overseen locally by the medical director with support from the administration team.

The service had a resident medical officer (RMO) on site 24 hours each day, 7 days a week. RMO staff said they had always been able to reach a consultant for advice or they had attended the ward if needed.

Good

Surgery

Surgery was consultant led and delivered for private and NHS patients. Consultants reviewed patients during daily ward rounds. The resident medical officer (RMO) reviewed patients before surgery and after if required. The RMO was included in morning and evening staff handover of patients to make sure that they were aware of medical conditions and associated risks.

The service always had a consultant on call during evenings and weekends. Weekend ward rounds were completed by the on-call consultant. Theatre staff were kept on standby for any patients who required urgent treatment after surgery.

In addition to each consultant being on call for their own patients, the service had a consultant surgeon and consultant anaesthetist on call 24 hours a day, every day.

A physician associate role had been introduced in the hospital. This was a new role in the UK designed to supplement the medical workforce. A physician associate is a healthcare professionals who, although not a doctor, works to the medical model of clinical diagnosis, with the attitude, skills and knowledge base to deliver holistic care and treatment within the general care team under defined levels of supervision.

Records

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

Patient notes were comprehensive and all staff could access them easily. Patient notes were a combination of electronic and paper form and contained the patient's surgical pathway, each consisted of a list of daily medicines, risk assessments, NEWS2 and multi-disciplinary records.

Records were stored securely. Paper records were stored securely in the ward office, electronic records were password protected.

Documentation audits were undertaken 6 monthly. Following our inspection, we reviewed the most recent documentation audit from August 2022. Out of 22 theatre patient records, the service achieved 88.84% compliance. Areas which were flagged as not meeting general standards included; entries being legible, concise and unambiguous, and staff not completing the signature list. For assessment and consent there was one example where a copy was not given to the patient. We were not aware of any target for this, or any actions taken to improve this.

When patients transferred to a new team, there were no delays in staff accessing their records. Discharge summaries were sent to the patient's GP, we observed copies of this during our inspection.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, not all medicines were stored correctly.

Staff followed systems and processes to prescribe and administer medicines safely. All patient allergies were clearly recorded within patient notes, medicine charts and highlighted as a risk on the theatre schedule. Patients' medicines were reviewed regularly, and staff provided advice to patients and carers about their medicines. The pharmacy team were well embedded and provided support to all areas of the hospital.

Good

Surgery

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between health and care services. Pharmacy staff completed medicines reconciliation and handled any medicines related concerns.

We reviewed 8 patient records which showed staff completed medicines records accurately and kept them up to date. Audits showed staff were aware of safety alerts and incidents to improve practice.

However, we found 2 unlocked storage rooms which contained several types of intravenous medicines that were accessible to patients. These medicines should have been secured to comply with National Health Note Guidance. This was highlighted and resolved during our inspection.

Incidents

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

Staff knew what incidents to report and how to report them. Staff described the process for reporting all incidents and received feedback from managers.

Managers shared learning with their staff about serious incidents and never events that happened elsewhere in the group during monthly clinical governance days. The service reported no never events.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if, and when things went wrong. Managers shared learning about never events and serious incidents with their staff and across the organisation.

Information from patient safety alerts were disseminated to staff verbally and by email as soon as they were received.

Staff received feedback from investigation of incidents, both internal and external to the service.

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

Are Surgery effective?

Good

We rated it as good.

Evidence-based care and treatment

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

Good

Surgery

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service undertook several service improvements in line with the National Institute for Health and Care Excellence guidance to achieve best outcomes for patients, such as promotion of physiotherapy before surgery to achieve quicker recovery. The service achieved 100% compliance with National Joint Register reporting.

National safety standards for invasive procedures were used to develop local safety standards for invasive procedures. These were used as a foundation for the Hospitals Audit program for invasive procedures. These audits were carried out by the hospital for NHS funded patients as recommended by NHS England and Improvement.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice, although the service did not usually treat these patients.

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

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink including additional choices for patients with specialist nutrition and hydration needs. Diabetic patients were discussed at planning meetings and prioritised for early surgery.

All patients we spoke with were very happy with the choice and quality of food provided, including their cultural and religious preferences. Catering staff worked until 7pm, nurses had access to the kitchen after this time.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. We reviewed 8 patient records which showed consistent recording of food and fluids given to patients.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. If catering staff noticed a patient was not eating or drinking, they would inform nursing staff.

Pain relief

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

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

Patients told us that they were given pain relief very soon after requesting it and often without making a request.

Staff prescribed, administered and recorded pain relief accurately. We saw this accurately recorded on patient medicine charts.

Good

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 service submitted relevant data to external organisations such as Patient Report Outcome Measures. This is a measure of health gain in patients undergoing hip or knee replacement surgery and is completed using a survey before and after surgery. The most recent data from April 2020 to March 2021 showed the number of patients who reported an improvement in Oxford knee replacement surgery was 98.2% and Oxford hip replacement surgery was 98%. Both were higher than the England averages of 97.2% and 94.1% respectively.

The service provided us with an example of guidance for patients with risk of having low sodium in their blood following surgery. They introduced a standard operating procedure which included further checks with their GP and medicines alterations to avoid potential acute kidney injury.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers reviewed this at monthly clinical governance meetings and used information from the audits to improve care and treatment.

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. Patient requirements were discussed at weekly planning meetings along with adequate staffing skill mix.

Managers gave all new staff a full induction tailored to their role before they started work. We reviewed 4 staff files which held completed induction booklets for all staff. Safety was promoted in recruitment process including safety checks.

Managers supported all staff to develop through yearly, constructive appraisals of their work. The service was 100% compliant with annual staff appraisals. Staff said that managers were supportive and encouraged them to develop their skills. Performance issues were overseen centrally by a specialist team covering recruitment, educational training and performance management.

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

Managers said that all consultants are employed purely by the service and do not work at local hospital trusts, so practising privileges did not apply.

Multidisciplinary working

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

Service managers held weekly meetings to discuss planned surgery admissions and allocated resources appropriately. Discharge planning was discussed during this meeting to ensure that all aspects of patient care was considered and did not delay their recovery.

Good

Surgery

We were told about a scenario where an inappropriate referral from the local hospital trust had resulted in a significant delayed discharge. The patient was waiting for a new placement to be built, the service recognised the extenuating circumstances and delayed their discharge until the accommodation had been built. This involved close liaison with their social worker, local hospital trust and community support.

Staff told us how they integrated with different teams, services and organisations to ensure continuity of care. Staff ensured people received consistent coordinated, person-centred care and support when they used, or moved between different services.

The hospital did not have a cancer specific service.

Seven-day services

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

The service employed 2 on-site Resident Medical Officers (RMO) who worked alternate weeks for 24 hours each day, 7 days a week. Staff said they sought immediate support from the RMO, who would escalate to the consultant if required.

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

Staff could call for support from physiotherapists, diagnostic services and theatre staff 24 hours each day, 7 days a week.

Health promotion

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

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

Staff assessed each patient's health from pre-admission and throughout their hospital treatment. Staff provided information regarding smoking cessation, alcohol intake, diet and exercise to improve the patient's recovery from surgery.

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. However, not all staff were up to date with training.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We checked patients records and confirmed that patients were fully consented before treatment.

Staff made sure patients consented to treatment based on all the information available and clearly documented this in patient records. All patient files that we reviewed had correctly completed consent forms.

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

Good

Surgery

The service did not have any patients subject to a Deprivation of Liberty Safeguards at the time of inspection. Staff described their understanding of this process and knew how to access policy and further information, including Mental Capacity Act.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Following our inspection, we were provided with training data that confirmed 81% of staff were compliant with combined Mental Capacity Act and Deprivation of Liberty Safeguards training. We were not provided with compliance data for each department as requested.

Are Surgery caring?

Good

We rated it as good.

Compassionate care

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

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

Patients said staff treated them well and with kindness. The service collected monthly patient and family feedback, results from October 2022 showed that 97.6% of patients rated their experience as good.

Staff followed policy to keep patient care and treatment confidential. We observed patient handovers were facilitated in the ward office to maintain confidentiality.

Staff showed understanding and a non-judgemental attitude when discussing patients with different social, cultural and religious beliefs to their own. All patients were offered a chaperone to accompany them throughout any examination or procedure.

Emotional support

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

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

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Patients said staff were very kind and understanding of their fluctuation in mood following surgery.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. The provider had a dedicated room to discuss distressing information with patients and their families.

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. We observed staff showing empathy to patients about their condition and the impact that this had on their lives.

Understanding and involvement of patients and those close to them

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

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

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Treatment options were discussed with patients during pre-assessment and patients were supported to choose their preferred treatment.

Patients were given a discharge pack with follow up support information.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave consistently positive feedback in postal and on-line surveys. Friends and family test feedback from May, June, July and October 2022 showed an average of 99% rated their experience as good.

The service was not facilitating routine family visits as a result of COVID-19 but were revisiting this as a result of patient feedback.

Are Surgery responsive?

Good

We rated it as good.

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the needs of the local population. We observed scheduling meetings that took place up to 3 weeks before planned surgery.

Facilities and premises were appropriate for the services being delivered.

Staff could access emergency mental health support for patients 24 hours a day 7 days a week. The service had a dementia lead to provide support for patients.

Managers ensured that patients who did not attend appointments were contacted.

Good

Surgery

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Any additional patient requirements were discussed at admission scheduling meetings and shared with all staff as necessary.

Wards were designed to meet the needs of patients living with dementia. There was a dedicated dementia room on the ward.

Staff supported patients living with dementia and learning disabilities by using a 'This is me' patient passport. This was given to the patient in the outpatient department and stayed with them throughout their patient journey. This enabled patients to submit details about themselves and their likes and dislikes to ensure staff were aware of their preferences. There were activity packs, fiddle muffs and handbags available on the ward which helped patients to relax.

There was a dementia lead who had undertaken dementia training along with other staff on the ward and from the outpatient department. The discharge manager liaised with the local NHS hospital and other partners to obtain this information before surgery took place and discussed in scheduling meetings.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff arranged familiarisation visits and liaised with social workers to achieve effective care throughout the hospital.

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

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service had an electronic device with instant access to over 200 interpreters who were available by phone and video call. British sign language was available by video link.

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

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 mostly in line with national standards.

During the Covid-19 pandemic, the hospital followed government guidance to cease their routine work and supported the NHS with additional procedures such as plastics, vascular, urology, breast cancer and plastics trauma.. As a result of this, the hospital was not meeting the 18-week pathway but were working hard to reduce the referral to treat waiting time.

From November 2021 to October 2022, the service completed 5,423 (88%) surgical procedures on behalf of the NHS and 757 (12%) were privately funded.

Good

Surgery

Managers worked hard to keep the number of cancelled operations to a minimum. In the 12 months leading up to our inspection, the service had cancelled 146 operations. When patients had their procedures cancelled, we were advised that they were re-booked as soon as possible. Data provided after the inspection showed that not all procedures were re-booked within 28 days.

We observed a weekly scheduling meeting which included a review of the previous week's theatre lists and a preview of the week ahead. The meeting was attended by all departments in the hospital and was chaired by the hospital director. Discussions included equipment ordered, any reasonable adjustments, bed capacity, clinical requirements, support for the ward, any safety alerts and staffing levels. Any gaps were identified and actions taken to address them. The attendees told us it was the most important meeting of the week and ensured patient safety both in the hospital and at home following discharge.

Managers and staff worked to make sure patients did not stay longer than they needed to. To minimise the number of hospital visits, diagnostic scans were made for the same day as pre-admission assessment.

Managers and staff worked to make sure that they started discharge planning as early as possible. Discharge planning started at the pre-admission appointment, which included information about their post-operative recovery. Scheduling meetings were attended by the discharge co-ordinator to discuss any potential discharge delays before surgery.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed feedback forms in patient areas. Patients who had received NHS funded care were able to complain to the service or to their local hospital.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was made to improve the service. Most complaints related to communication problems between the teams across the hospital. We saw evidence of learning from complaints, such as introduction of a standard operating procedure (SOP) for staff to follow when considering cancellation of any appointments or theatres and required senior manager approval.

Complaint numbers were monitored. From November 2021 to October 2022, the service received 34 complaints.

Patients were invited to have telephone or face to face meetings with the hospital director if they were unhappy with the outcome of the investigation into their complaint.

The service was a member of the Independent Sector Complaints Adjudication Service (ISCAS) which provided independent analysis on complaints for ISCAS subscribers. ISCAS was a voluntary subscriber scheme, used by most providers of independent healthcare.

Good

Surgery

Are Surgery well-led?

Requires Improvement

We rated it as requires improvement.

Leadership

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

Leaders had the skills, knowledge, experience and integrity to run the service. Leaders understood the challenges to quality and sustainability, such as budget challenges and could identify actions needed to address them, in conjunction with the local integrated care board. Leaders recognised the dedication and professionalism of staff from all areas of the hospital.

Staff told us leaders were visible, approachable and explained a high level of support available during out of hours and weekends.

There were clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership. The leadership charter illustrated an inclusive and respectful culture. The service had a leadership strategy and development programme, which included succession planning.

Staff development included plans to support existing healthcare assistants to assistant practitioners with similar plans to replicate this process for theatre-based health care assistants.

At the time of our inspection, the interim hospital director had applied for the permanent hospital director vacancy. There was no registered manager, an application was due to be submitted to the Care Quality Commission.

Vision and Strategy

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

There was a clear vision and a set of values including quality and sustainability. The hospital embraced the corporate group vision alongside service and leadership charters.

There was a realistic strategy for achieving the priorities and delivering good quality sustainable care. Services had been planned to meet the needs of the relevant population. The service charter had built their services around 4 key principles of good customer service; personalised, competent, convenient and proactive. Progress against delivery of their strategy was monitored and reviewed at regular intervals during clinical governance and hospital manager meetings.

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

Good

Surgery

Culture

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

Staff felt supported, respected, valued and were proud to work in the organisation. We reviewed staff survey results from May 2022 where 93% of staff believed that the service embraced diversity and 89% of line managers empowered staff to make their own decisions.

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

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution, and appropriate learning and was action taken because of concerns raised. The culture encouraged openness and honesty at all levels within the organisation, including people who used services, in response to incidents.

There were mechanisms for providing all staff at every level with the development they needed, including high-quality appraisal and career development conversations. There was a strong emphasis on the safety and well-being of staff. Staff received free meals and an annual Christmas lunch was served by the hospital leadership team. Other staff incentives included Practice Plus Group excellence awards and localised hero of the month award.

Equality and diversity were promoted within and beyond the organisation. Staff, including those with protected characteristics under the Equality Act, felt they were treated equitably.

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

Governance

Staff had regular opportunities to meet, discuss and learn from the performance of the service. However, governance processes were not always effective including the monitoring and oversight of training and systems to respond to concerns about a person's fitness to practice.

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

Meetings looked at operational performance and included a review of incidents reported, complaints, audit, clinical outcomes, infection control, risks identified on the risk register and risk management, delayed discharges, cancellations, unexpected transfers, returns to theatre, readmissions, training and service improvements. The meetings were minuted and the actions required were monitored with details of the person responsible for those actions and a review date.

Monthly clinical governance meetings included a review of allocated actions, alongside an emphasis on training and learning. There were department meetings, heads of department meetings, quality and governance meetings. The service had a clinical governance training schedule for future months which included moving and handling, venepuncture, dementia information, decontamination of endoscopy and speech direct dictation.

Arrangements with partners and third-party providers were governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care.

Good

Surgery

There were not always effective governance processed for the monitoring and oversight of training performance. Managers monitored monthly training, however the skills matrix for each department did not match the overall mandatory training spreadsheet provided to the Care Quality Commission. There were significant discrepancies in training compliance data provided and was often different to previous documents supplied.

The service ensured all staff underwent appropriate checks as required by Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff were recruited in line with national guidance and the effective recruitment process ensured staff were competent, capable and confident in their area of practice. The hospital director was supported in the recruitment processes by the organisation's human resources department. Checks on staff continued professional registrations, where applicable, were undertaken annually.

We reviewed 10 staff electronic files and saw recruitment processes and checks were mostly completed. We saw evidence of sickness records, training, revalidation, occupational health adjustments and appraisal records. We found gaps in checks stored electronically. One consultant did not have evidence of a DBS check and 2 consultants only had 1 reference. This was likely to be an administrative error when moving files electronically and the provider was reviewing this.

There was not a robust system to respond to concerns about a person's fitness to practice. One consultant had previously worked in Plymouth, and at the time was under investigation by the General Medical Council for dishonesty. The Plymouth leadership team were not aware of the upcoming tribunal, dishonesty concerns relating to the ongoing investigation or previous history. This meant they were not able to ensure there was appropriate oversight and management of the consultant or able to provide the consultant with support for their wellbeing. The information about dishonesty was made available at recruitment and we saw evidence this was held electronically on file. The consultant's fitness to practice was approved by the provider's corporate Medical Director, evidenced by an email trail, but this had not been effectively communicated to the Plymouth location. There were no current restrictions to the consultant's registration, and they were able to continue to work as there were no patient safety concerns with their practice. However, there was no risk assessment to assess the consultant's fitness to practice, to document the decision the consultant was considered safe to continue working, with clear rationale, decisions and actions.

There were processes to review consultants ongoing performance. A monthly Decision Making Group was held provider wide, where fitness to practice concerns were discussed, and a list of clinicians of concern was held. The provider's corporate Medical Director confirmed they had oversight of all annual appraisals, and reported this to Board, and reviewed performance metrics for consultants. At a local level Plymouth's Medical Director held a full day governance session every other month, during this meeting performance data, audits, incidents and complaints were reviewed.

We reviewed information supplied by the service to the Private Healthcare Information Network (PHIN) including; volume of patients, length of stay, patient feedback, infections, consultant reference, health improvements, never events and incidents and found that this was being reported with no concerns raised.

Management of risk, issues and performance

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

Good

Surgery

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

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. Each department had their own risk register, which fed into the overall risk register for the service, with clear actions and responsibilities for relevant department managers. There was alignment between recorded risks and what staff said was 'on their worry list'.

We reviewed department and overall service risk registers; however training compliance was not highlighted as a risk.

Potential risks were considered when planning services, for example, seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. Impact on quality and sustainability was assessed and monitored. There were no examples of where financial pressures had compromised care.

Information Management

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

Information was used to measure improvement, not just assurance. Quality and sustainability both received coverage in relevant meetings at all levels.

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

When viewing, sending and discussing staff files staff adhered to a range of policies to ensure confidentiality. Their policies included general data protection regulation (GDPR), information security and computer use.

There were arrangements to ensure some data and notifications were submitted to external bodies as required, however this not was consistently completed.

Engagement

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

People's views and experiences were gathered and acted on to shape and improve the services and culture.

The provider used the friends and family test to allow patients to report on their experience. The test was available to complete on a tablet in most departments. Results were shared with staff in all departments. The staff received this as positive feedback but also took on board any constructive comments that helped to improve services. Response rates had improved and responses were positive.

Good

Surgery

There was a patient forum group (PFG) to enable a two-way dialogue between the provider and patients regarding elements of the patient experience. There were discussions about potential service developments and improvements with previous service users. The members of the PFG comprised of previous patients that had typically used services during the previous 18 months. Members would then serve on the group for 12 to 18 months before being replaced with more recent service users.

The provider was represented at group meetings by the hospital director and the outpatient manager. Other senior staff and service leads would attend meetings, dependent upon the nature of the subject matter due to be discussed.

The service had a chosen charity of the year. Fundraising took place throughout the year with lots of activities planned such as cake sales, raffles and collection tins in the café.

Staff survey results showed a downward shift in the answers to most key questions from the scores in 2020. The top 3 questions related to being informed about the impact of COVID-19 (94%); embracing diversity (93%); and the handling of COVID-19 by the leadership team (93%).

The bottom 3 questions related to pay and benefits (39%); career aspirations (59%); senior management empowering organisational goals (62%).

A regional HR manager oversaw employee issues such as disciplinaries and grievances and supported line managers during regular visits to the hospital every 2 weeks.

There was a 'people plan' with a monthly steering group to monitor progress of the plan. Key elements included a retention tool kit, talent management and practice.

A wellbeing champion was based in an office in the hospital. They provided a neutral approach and a signposting service to direct staff towards the various groups that might be able to help. They also worked closely with the safeguarding lead, should this be required.

Staff received a number of benefits including:

- a bonus in February
- 2 free lunch passes per month
- chocolate gifts at Easter
- a lunch served by the senior management team at Christmas
- a birthday card
- free car parking on site or at a nearby site.

There were several award schemes including: employee of the month and medical professional of the year.

Learning, continuous improvement and innovation

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

Good

Surgery

Leaders and staff aspired to continuous learning, improvement and innovation. Since August 2021 the service had completed a trial of new knee replacement and surgical method called Medacta GMK Sphere Trial with better patient outcomes achieved for patients following knee surgery.

The service had supported a member of staff to attend Chrysalis training to provide wellbeing support to staff and patients.

This was in addition to the small numbers of fast-tracks that were provide to the local serving military who were about to deploy and needed surgery in order to remain operational. This was specific to the hospital and specific referral sickbays locally.

There service used an innovative waste management system which collected, transported and disposed of hazardous fluid waste and surgical smoke during surgery. Surgical fluids were collected into a mobile suction unit and then automatically disposed of directly to the sluice drain via a docking station, saving on waste costs. There were direct and indirect cost savings such as reduction in waste fluid collection from theatres and reduced clinical waste. Other benefits included a reduction in carbon footprint due to a reduced incineration waste.

Staff regularly took time out to work together to resolve problems and to review individual and team objectives, processes and performance which lead to improvements and innovation such as improved checklists for completion during patient recovery and improved use of nurse-led patient discharge. There were systems to support improvement and innovation work, including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work.

Good

Outpatients

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

Are Outpatients safe?

Good

We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff. However, not all staff had completed it.

The mandatory training met the needs of patients and staff. Staff told us they were given protected time to complete mandatory training. Seventy three percent of outpatient staff had met the 90% training compliance target. We were told this was due to new staff joining the service, the introduction of a new electronic training system and two new mandatory training modules.

Managers monitored mandatory training, however the outpatient department skills matrix did not match the overall hospital mandatory training. The overall mandatory training spreadsheet showed 3 members of outpatient staff were out of date for basic life support (BLS) training. Whereas the outpatient department matrix showed 10 staff were out of date for their annual face to face BLS training. Outpatient staff had completed an appropriate level of resuscitation training.

Clinical staff completed training on recognising and responding to patients with learning disabilities, autism and dementia. The hospital had arranged dementia simulation training for staff. Staff completed training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) however, only 67% of outpatient staff were in date for this training.

There was no training for recognising and responding to patients with mental health needs or violence and aggression. Staff described to us increased challenges when dealing with more violent and aggressive patients or speaking with patients with mental health needs.

Safeguarding

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

Nursing staff received training specific for their role on how to recognise and report abuse. There were 10 members of staff eligible for safeguarding adults level 3 training and 8 were in date. All staff were in date for safeguarding children level 2 training.

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They had worked with local agencies to provide additional training including modern day slavery and domestic violence.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the department.

Cleanliness, infection control and hygiene

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

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

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff cleaned equipment after patient contact and were bare below the elbow. Staff followed infection control principles including the use of personal protective equipment (PPE).

Handwash gels were available at sinks along with signage for correct handwashing procedures. The hospital had an infection prevention control link nurse. The handwashing audit showed 96.3% compliance and the environmental audit showed 96.5% compliance in October 2022. The cleaning audit showed 100% compliance in November 2022.

The privacy curtains were disposable and were last changed in September 2022.

Environment and equipment

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

Staff carried out daily safety checks of specialist equipment. The service had enough suitable equipment to help them safely care for patients. The resuscitation trolley for the outpatient department and diagnostic imaging department was housed in the outpatient department.

The service had suitable facilities to meet the needs of patients' families. The waiting area had enough seats for chaperones to sit with patients.

Staff disposed of clinical waste safely. The domestic and clinical waste bins were clearly identified and emptied regularly. The sharps bins were stored safely.

The layout of the department meant patients that had infectious diseases were able to be seen. There was a room called the annexe at the end of a corridor. The annexe had a separate entrance that would be deep cleaned after any contact with an infectious disease, such as Covid-19. The department had a national accreditation body for the United Kingdom (UKAS) certificate.

Assessing and responding to patient risk

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

Staff responded promptly to any sudden deterioration in a patient's health. Staff had access to emergency bells in consulting and treatment rooms.

Staff completed risk assessments for each patient on arrival, using a recognised tool. Staff knew about and dealt with any specific risk issues. Patients were given wound, pulmonary embolism (PE) and venous thromboembolism (VTE) advice leaflets. These provided information about how to recognise the symptoms and what to do if the situation arose. We were told of an example when a patient had attended for a pre-assessment appointment and received an electrocardiogram (ECG). (An ECG is a test that is used to check the hearts rhythm and electrical activity). The ECG had identified a problem and the patient was escalated to the local NHS Trust for investigation.

Staff arranged referrals for patients to receive specialist mental health support. We observed a pre-assessment clinic where a patient was incredibly anxious about sedation. They opened up to staff about what exacerbated their anxiety. The nursing and medical staff were extremely compassionate and sought the patients consent to refer them for professional support.

We were told patients thought to be at risk of self-harm or suicide would be referred to speak with the nurse in charge to go through a risk assessment prior to onward referral for help. The check list included details of the 24/7 crisis line, mental health first aiders within the hospital, safeguarding lead and external agencies to contact.

Staff shared key information to keep patients safe when handing over their care to others.

Shifts had staggered starts which meant not all staff could attend a morning team brief. We were told this was due to be re-introduced but staff received an individual brief when they started their shift.

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.

The outpatient department had enough nursing and support staff to keep patients safe. There was:

- an optometrist
- a nurse in charge
- a deputy nurse
- 5 additional registered nurses
- 1 assistant practitioner
- 3 full time healthcare assistants
- 1 part time healthcare assistant and,

- a coordinator.

Senior managers adjusted staffing levels according to the needs of patients and devised a rota two months in advance. The number of nurses and healthcare assistants matched the planned numbers. A physician associate was also available within the department. A physician associate role had been introduced in the hospital. This was a new role in the UK designed to supplement the medical workforce. A physician associate is a healthcare professional who, although not a doctor, works to the medical model of clinical diagnosis, with the attitude, skills and knowledge base to deliver holistic care and treatment within the general care team under defined levels of supervision.

However, the ophthalmology service had recently lost nursing staff and had reduced its service. There was 1 ophthalmic nurse and an ophthalmic healthcare assistant and 2 nurse vacancies. This was on the risk register and the service were trying to recruit to these posts. Since the inspection, the service told us they had recruited a full-time ophthalmic nurse and a part time optometrist.

The service did not use bank or agency nurses.

Records

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

Patient notes were mainly electronic, comprehensive and all staff could access them easily. The ophthalmology department had to use two different types of software to input patient information.

Records were stored securely.

The outpatient documentation audit dated 2 December 2022 was 100% for pre-operative appointments, multi-disciplinary team assessment and general standards.

Medicines

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

The department did not routinely prescribe medicines.

Nurses had completed patient group direction training. *Patient Group Directions* (PGDs) provide a legal framework that allows some registered health professionals to supply or administer specified medicines) for patients that required pupil dilating eye drops.

Staff followed systems and processes to prescribe and administer medicines safely.

Staff completed medicines records and stored prescribing documents safely.

Incidents

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

Good

Outpatients

For our main findings please refer to the surgery report.

Staff knew what incidents to report and how to report them. There had been a total of 33 incidents reported in outpatients between November 2021 and November 2022. Staff raised concerns and reported incidents in line with the service's policy. Staff received feedback from investigation of incidents.

Staff reported serious incidents clearly and in line with the service's policy.

The service had reported no never events. Managers shared learning with their staff about never events that happened elsewhere in the group.

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

There was evidence that changes had been made as a result of feedback. We were told of an example where a patient had their surgery cancelled on the same day due to medication that had not been stopped before surgery. As a result of this, the outpatient department had introduced a stop medication letter on orange paper which was given to the patient and scanned onto the patient's electronic record after being discussed with the nurse.

Are Outpatients effective?

Inspected but not rated

We do not rate effective.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The department followed National Institute for Health and Care Excellence (NICE) guidance to achieve effective outcomes for patients.

Staff were aware of the psychological and emotional needs of patients.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Staff made sure patients had enough to eat and drink. A water cooler was available in the main foyer so patients could help themselves. Patients could purchase food from the hospital's canteen situated next door to the outpatient department.

Pain relief

Staff gave pain relief in a timely way if required. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Good

Outpatients

Patients told us they received pain relief soon after requesting it. Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff told us they did not routinely prescribe medicines but there was a duty resident medical officer (RMO) or consultant they could seek support from.

Patient outcomes

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

For our main findings, please refer to the surgery report.

We were told that patients were normally on a pathway associated with a different department and their treatment outcomes were monitored in the other areas, most often by surgery.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. Managers supported staff to develop through yearly, constructive appraisals of their work. Staff were in date for their appraisals.

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

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We heard senior managers had supported a member of staff to attend college in order to progress to a promotion.

Managers made sure staff received any specialist training for their role. The new ophthalmology team had received training courses and were in the process of sourcing an eye anatomy course.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

The senior management team had worked towards providing one-stop clinics so patients could see all the health professionals involved in their care on the same day. This had been a regular practice prior to Covid-19 but was postponed during the pandemic. However, not all patients received a one-stop clinic due to capacity.

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

Seven-day services

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

Good

Outpatients

Staff could call for support from doctors and other disciplines within the hospital. The service operated five days a week from 8am to 5:30pm with occasional weekend clinics on Saturdays when required.

Health promotion

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

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle. Nursing staff told us the importance of offering support and advice to lead healthier lives.

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. However, not all staff were in date with their Mental Capacity Act (MCA) and Deprivation of Liberty Safeguard (DoLs) training.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained verbal and written 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 clearly recorded consent in the patients' records.

Staff understood how and when to assess whether a patient had the mental capacity to make decisions about their care. Staff gave us examples of when they had raised concerns about a patient's ability to give consent, who they had involved and the outcomes.

However, during our inspection, 67% of staff in the outpatient department had completed up to date MCA and DoLs training.

Are Outpatients caring?

Good

We rated it as good.

Compassionate care

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

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

Patients said staff treated them well and with kindness. Staff followed policy to keep patient care and treatment confidential.

Good

Outpatients

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for, or discussing patients with mental health needs. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

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

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

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed a pre-assessment clinic where a patient was extremely anxious. Staff reassured the patient and explained that on the day of surgery they would put them first on the list so they would not have a long wait.

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

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff talked with patients, families and carers in a way they could understand. We saw communication aids that could be used when necessary to support people with additional needs.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Between 1 October 2022 and 31 October 2022, the outpatient department had received 225 patients' feedback which was 100% good and ophthalmology had received 95 patients' feedback which was 100% good.

Patients gave positive feedback about the service. We saw patients had written "very good communication with the nurses and healthcare assistants, extremely helpful and explained everything in detail whilst making me feel at ease" and "I was so nervous, normally people can't get my blood saw the healthcare assistant today, she calmed me down and let me lie on the couch. She got it with no problems, and it didn't hurt". We spoke with 7 patients during the inspection and all the feedback was positive.

Are Outpatients responsive?

Requires Improvement

We rated it as requires improvement.

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. However, there was a large backlog as the hospital had provided the local NHS Trust with support during the Covid-19 pandemic.

Good

Outpatients

Managers planned and organised services so they met the changing needs of the local population. During the Covid-19 pandemic, the hospital stopped the majority of their routine work (orthopaedic, endoscopy and general surgery) and supported the National Health Service (NHS) with additional clinics for plastics (trauma and cancer), orthopaedic trauma, breasts, urology, vascular, gynaecology, and ear nose and throat (ENT). This meant outpatients delivered trauma, burns, gynaecology and vascular clinics.

Prior to the Covid-19 pandemic, the service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. The hospital had a plan to reinstate this.

Facilities and premises were appropriate for the services being delivered. Patients had access to accessible parking, accessible toilets and there was a lowered reception desk. The outpatient department ran an occasional Saturday clinic. However, the department was sharing its premises to allow an out of hours general practice (GP) service to run overnight and at weekends. This meant the outpatients clinic had to finish at 5:30pm during the week and share the department during any weekend clinics.

The service had systems to help care for patients in need of additional support or specialist intervention.

Managers monitored and took action to minimise missed appointments. Patients were contacted by telephone to arrange an initial appointment and were also sent a letter.

Managers ensured that patients who did not attend appointments were contacted. This was attempted on 3 separate occasions and a letter was also sent.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Patient needs were identified at pre-assessment appointments. The hospital had a dementia link nurse.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had access to communication aids to help patients become partners in their care and treatment.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service had a portable tablet device that could translate languages spoken by the patients and local community. The tablet could access video links instantly, including British Sign Language, staff told us how they used this for patients often.

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

Access and flow

People could access the service when they needed it and received the right care. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Good

Outpatients

During the Covid-19 pandemic, the hospital stopped all of their routine work and supported the NHS with additional clinics for cancer pathways and trauma. As a result of this, the hospital was not meeting the national standard but were working hard to reduce the referral to treat waiting time. The booking team had recently increased in size and a triage team actively monitored and risk assessed the waiting list. Patients on the waiting list were considered in chronological order whilst looking at those in severe pain and with mobility issues.

In the last 12 months 23,507 patients had attended appointments, 1,112 patients had cancelled their appointments and 2,440 had their appointment cancelled. When patients had their appointments cancelled at the last minute, managers tried to rearrange them as soon as possible.

Managers and staff started planning each patient's discharge as early as possible. Questions around patients support post-surgery was discussed at the pre-assessment appointment.

Learning from complaints and concerns

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

For our main findings, please refer to the surgery report.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Managers shared feedback from complaints with staff and learning was used to improve the service. We were informed of an example where a patient had tripped and fallen down some steps in the annexe and these had been replaced with a slope.

The outpatient department had received 13 complaints between November 2021 and October 2022. There had been an increase in patient complaints due to cancellation of surgery on the day with no clear plan for rebooking. The department introduced a cancellation on the day of surgery standard operating procedure that ensured all options to prevent cancellation had been considered, the patient had a plan for future surgery and a contact number provided if unable to provide a date.

Are Outpatients well-led?

Good

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.

For our main findings please refer to the surgery report.

Good

Outpatients

Staff told us their line manager and senior management team were visible and approachable.

The hospital director was focused on the outpatient waiting list and reintroducing the same day appointments for patients.

Vision and Strategy

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

For our main findings please refer to 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.

For our main findings please refer to the surgery report.

Staff felt supported, respected and valued. They were positive and proud to work for the hospital. Teams and staff worked collaboratively and shared responsibility. The culture was centred on the needs and experience of people who used services.

Staff told us they felt supported by their colleagues and they enjoyed working for the organisation. The staff had access to a wellbeing champion and mental health first aider.

There were mechanisms for providing staff at all levels with the development they required, including appraisal and career development conversations.

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.

For our main findings please refer to the surgery report.

Staff were clear about their roles and understood what they were accountable for, and to whom. Managers held regular meetings and shared minutes with staff who could not attend. The minutes showed evidence of sharing incidents, audits, review of risks, information about training and changes to policy. We were told learning from incidents and complaints was discussed; however this discussion was not documented in meeting minutes.

Managers monitored mandatory training however the outpatient department skills matrix did not match the overall hospital mandatory training spreadsheet. The overall mandatory training spreadsheet showed three members of outpatient staff were out of date basic life support (BLS) training, however the outpatient department matrix showed 10 staff were out of date their face to face BLS training.

Good

Outpatients

Management of risk, issues and performance

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

For our main findings please refer to the surgery report.

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. The department had its own risk register.

Staff informed us there had been a rise in violence and aggression. There was an assistance button on their computer screen for all staff to use if they felt threatened. This would alert the team to an issue and raise the alarm for help. However, we could not see that violence and aggression training was offered as part of mandatory training.

Information Management

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

For our main findings please refer to the surgery report.

Information was used to measure improvement, not just assurance within the department. For example, a friends and family tablet was used to gather patient feedback and a website was used to gather enquires from the public.

Engagement

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

For our main findings please refer to the surgery report.

Patients and families could give feedback on the service and their treatment. Patient feedback was collected at the end of their appointment through a portable tablet. Staff were invited to take part in satisfaction surveys. Staff were encouraged to attend the monthly team meeting and share their views.

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.

For our main findings please refer to the surgery report.

Good

Diagnostic and screening services

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

Are Diagnostic and screening services safe?

Good

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 through the mandatory training programme. Most staff were up to date with their training or had dates booked to attend training in the near future and were up to date with their skills and knowledge to enable them to care for patients appropriately. Records showed 82.75% of staff had completed their training against a target of 95%. The overall percentage had been reduced as a member of staff had been unable to attend due to absence.

The mandatory training was comprehensive and met the needs of patients and staff. Staff told us mandatory training updates were delivered to meet their needs and they were able to access training as they needed it. Mandatory training was available using a range of methods to maximise accessibility, including face-to-face sessions and e-learning.

The training programme covered a range of topics including autism learning, chaperoning, clinical governance, duty of candour, equality and diversity, health and safety, infection prevention and control, information governance and data protection, and moving and handling.

Most staff were compliant with face to face basic life support (BSL) and immediate life support (ILS) training where required or had dates booked to attend training in the near future. Although staff in diagnostics only had to complete BLS training, it was preferred they completed ILS training too. BLS and ILS was provided by in-house trainers who were tasked to ensure training remained up to date.

Staff completed training on recognising and responding to patients with learning disabilities, autism and dementia. The hospital had arranged dementia simulation training for staff. However, there was no training for recognising and responding to patients with mental health needs or violence and aggression. Most staff had completed training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs).

Managers monitored mandatory training and alerted staff when they needed to update their training. Performance reports were available to review training attendance and staff could check their compliance with mandatory training. Managers saw which members of their team were in date and were able to plan when team members needed to complete refresher training. Email reminders were sent to all staff reminding them in advance of when the training was due. Compliance was reported monthly as part of the governance report.

Training compliance was also monitored centrally by Practice Plus Group Hospitals Limited.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Staff maintained up-to-date mandatory e-learning, which included Safeguarding Adults level 3 and Safeguarding Children level 2. Training compliance was 100%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. The service used the latest legislation in policies and procedures.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were knowledgeable about the safeguarding policy and processes and were clear about their responsibilities. They described what actions they would take should they have safeguarding concerns about a patient. All staff were confident to challenge to ensure the safety of patients.

Staff followed safe procedures for children visiting the departments. Information for staff was within safeguarding policies and procedures. This included the action to take when staff had concerns regarding child protection and domestic abuse.

There had been no safeguarding referrals during the last 12 months.

Cleanliness, infection control and hygiene

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

All areas were clean and had suitable furnishings which were clean and well-maintained. In all areas we visited, the floors, walls, and areas in general were visibly clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. A cleaning folder contained an infection prevention and control policy, a radiology department cleaning policy and cleaning environments standard operating procedures (SOP). There were guides covering COVID-19, radiology equipment cleaning and the storage of disinfectants.

There were cleaning schedules, daily checks and procedures for the X-ray rooms, offices and waiting area. Daily checks for the period from February to October 2022 showed 100% compliance apart from three months when the score was 95%.

Good

Diagnostic and screening services

There was a dedicated team of cleaning staff who ensured the areas were clean and tidy and they were fully integrated with the clinical teams. There were daily schedules and weekly tasks, alongside deep cleaning as and when required.

Staff followed infection control principles including the use of personal protective equipment (PPE), such as face masks and gloves to protect and prevent healthcare-associated infection. These were readily available to staff.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Changes to cleanliness processes and practices were implemented and communicated to staff.

Precautions were taken when seeing patients with suspected communicable diseases such as influenza. Where a patient was known or suspected as having a communicable disease, deep cleaning would be conducted after the X-ray.

Regular infection prevention and control audits were completed. For most months no areas were identified for action in the X-ray department. From the audit in September 2022 some slight damage was identified to the bottom left of the door to the back corridor. This was resolved as part of the fire door upgrade.

Results from audits of cleaning and decontamination of reusable equipment showed 100% compliance.

Staff, patients and visitors to the department had access to antibacterial gel and handwashing facilities. We saw these used regularly throughout our inspection. Staff washed their hands and applied antibacterial hand gel between each patient contact. We also saw non-clinical staff, including administration staff using hand gel. The antibacterial hand gel was located at the entrance to the hospital and the outpatient department. Audits of hand hygiene and technique were 100% compliant.

Environment and equipment

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

The design of the environment followed national guidance for safety. There were 2 X-ray rooms, an office, reception area and waiting area. X-ray equipment had been installed in 2020 to enhance the digital radiography capacity. There was also a digital mobile X-ray machine.

The service had suitable facilities and equipment to safely meet the needs of patients. Staff said they had access to the equipment they needed for the care and treatment of patients. They had enough space to move freely through the department. Staff explained that a bariatric wheelchair was available if required. Appropriate toilets were available for all patients.

There was access to emergency equipment. The emergency trolley, located in the adjoining outpatient department was clean, tamper evident and ready to use. Staff carried out daily and weekly checks of the equipment and medicines to ensure they were ready to use and in date. From the records we reviewed during a three-month period there were no gaps in the log.

Staff disposed of clinical waste safely. Disposable items of equipment were discarded appropriately, either in clinical waste bins or sharp instrument containers. Staff said these were emptied regularly and none of the bins or containers we saw were unacceptably full.

The service had an equipment quality assurance programme for the X-ray equipment. Medical physics expert (MPE) advice was provided as required by the Ionising Radiations (Medical Exposure) Regulations 2017 on optimising clinical procedures. A radiation protection advisor (RPA) was also appointed under the 2017 Regulations. The RPA conducted annual on-site audit of compliance with the regulations, provided a personal dosimetry service and advice on Medicines and Healthcare products Regulatory Agency (MHRA) safety notices.

Protocols were completed for the digital radiography machines and a review was planned before the end of the year. Equipment was calibrated and warmed up every day.

There were service contracts for equipment and a clear process for maintenance of equipment and for reporting of any faults. Annual servicing included an annual medical physics performance assessment of X-ray equipment. All tests and work on equipment were performed in accordance with professional guidance. This incorporated technical protocols defined in IPEM Report 91 "Recommended Standards for the Routine Performance Testing of Diagnostic X-Ray Imaging Systems". These equipment surveys included collation of the data, analysis of the results and a written report with any recommendations on corrective action as necessary.

Staff carried out daily safety checks of specialist equipment. X-ray equipment underwent daily quality assurance checks and staff could describe what they would do if any of the checks fell outside of acceptable ranges. Other specialist equipment such as the assay calibration device, were checked daily and serviced annually.

The service monitored staff for radiation exposure using dosimeters. Dose reports were reviewed by the manager on a regular basis. We saw dose restricted levels were in order and completed.

The service had completed risk assessments for all new or modified uses of radiation, which were reviewed every two years or whenever a change occurred. This was last undertaken in December 2021 and signed off by the medical physics expert.

Risk assessments addressed occupational safety as well as considering risks to people who used services and the public. For example, doses of radiation to members of the public and to patient escorts, such as nursing staff.

The service ensured controlled areas (where ionising radiation was present) were restricted to authorised personnel only. There was clear signage when ionising radiation exposure occurred and a physical fabric barrier across the X-ray room doors to prevent accidental access.

The team had liaised with patients about the décor in the department. They had obtained a straw poll about the environment and the colour of the walls and decorated the walls in the colours suggested. Other decorations were adorned at the reception desk. During our visit we saw bunting arranged above the reception desk and staff explained there would be other seasonal decorations, for example for Christmas.

A jar full of sweets was available at the reception desk for patients to take as they left the department and all patients we spoke to remarked on the kindness of the gesture.

Assessing and responding to patient risk

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

Good

Diagnostic and screening services

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments relating to patients needs were completed and evaluated.

Staff responded promptly to any sudden deterioration in a patient's health. Staff knew about and dealt with any specific risk issues. There were clear pathways and processes for the management of people who were, or became, clinically unwell. Staff were able to seek support from the resident medical officer and consultants when patients deteriorated and would consider calling emergency services.

Staff would contact the radiologist when an immediate report was required. The service ensured the radiation protection advisor and the medical physics expert were easily accessible to provide radiation advice.

There were processes and checks to ensure the right person got the right X-ray.

The service followed the Royal College of Radiologists' Standards for the communication of radiological reports and fail-safe alert notifications. X-rays were uploaded to the electronic system which was accessed by the IR(ME)R licence holder or another approved reporter.

The service ensured radiation doses were kept as low as reasonably practicable. The service had a set of local rules and employer's procedures available to protect staff and patients from ionising radiation.

The service ensured staff were aware of women who were or may be pregnant before they were exposed to any radiation in accordance with IR(ME)R and for staff in accordance with Ionising Radiation Regulations (IRR) 2017.

There were clear processes to escalate unexpected or significant findings both at the examination and upon reporting.

Patients who become critically ill or required specialist care would be transferred promptly to the local NHS trust. A service level agreement (SLA) outlined the arrangements for the transfer of patients who required a higher level of care. There was a strict admission criteria and patients were only accepted if medically suitable for treatment in such an environment. The SLA also covered all the radiation protection services required, based on the historical configuration of services.

Services were accredited to ISO9001:2015 and were delivered in line with the appropriate quality and safety standards.

Staffing

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

The service had a radiology manager, a senior radiographer, 2 radiographers and 2 administration coordinators. The number of staff matched the planned numbers. The manager accurately calculated and reviewed the number of radiographers needed for each shift.

The service did not use bank or agency staff.

We viewed staff electronic files and saw recruitment processes and checks, sickness records, training, occupational health adjustments and appraisals.

Good

Diagnostic and screening services

Records

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

All patient records and referrals were electronic. They were comprehensive and all staff could access them easily. There were no delays in staff accessing the records.

The service ensured imaging requests were appropriate and included the relevant information to allow for requests to be justified in accordance with Ionising Radiation (Medical Exposures) Regulations (IR(ME)R).

We reviewed 4 patient request forms and saw all required information was present on all 4 forms, including protocols and medical history. We looked at four X-ray reports. All adhered to the Royal College of Radiologists reporting standards, such as description and conclusion.

We also reviewed 4 X-ray reports. All were sufficient to adhere to the Royal College of Radiologists reporting standards, for example, description, conclusion and diagnosis.

Completion of records was regularly audited and actions were taken to address any shortfalls. A diagnostics clinical practice review and documentation audit was completed regularly. Compliance with diagnostic standards was 100% in October 2021 and August 2022. In February 2022 it was 95.83%.

Medicines

There were systems and processes to safely prescribe, administer, record and store medicines.

Staff had undertaken medicines management training. However, the department did not routinely use medicines or controlled drugs.

Audits showed staff were aware of medicine safety alerts and incidents to improve practice.

Incidents

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

Staff reported serious incidents clearly and in line with the provider's policy. There were systems to make sure incidents were reported and investigated appropriately. Staff were open, transparent and honest about reporting incidents and said they would have no hesitation in reporting incidents. Staff said they were encouraged to report incidents promptly.

Staff knew what incidents to report and how to report them. They were clear about how they would report them. All incidents were reported directly onto the incident reporting system. This provided a single record of each incident, subsequent investigation, agreed learning, and evidence of the learning and its effectiveness.

Reports from investigations showed managers investigated incidents thoroughly. The incident reporting policy set out the processes for reporting and managing incidents and described the root cause analysis investigation process and the roles and responsibilities of staff involved in the process.

Good

Diagnostic and screening services

Managers shared learning about never events and serious incidents with their staff. Learning from incidents started at the point where the event happened, with any necessary local action being taken to minimise a similar event from reoccurring.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation and apology when things went wrong. We discussed an incident where duty of candour had been applied and staff demonstrated an understanding of their responsibilities and could describe the process and what they would do.

The service had not recorded any never events. During the period between 14 November 2021 and 14 November 2022 there had been 4 incidents reported.

From the minutes of the radiology meeting and governance meeting we saw the incidents were discussed and learning shared. Managers also shared learning about incidents and learning from other hospitals in the group.

There had been no incidents reportable under Ionising Radiation (Medical Exposures) Regulations (IR(ME)R) in the 12 months prior to our inspection.

Are Diagnostic and screening services effective?

Inspected but not rated

We do not rate effective.

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. Care, treatment and support was delivered in line with legislation, standards and evidence-based guidance, including the National Institute for Health and Care Excellence (NICE) guidance and other expert professional bodies, to achieve effective outcomes.

Policies and procedures were available to all staff. For example, in relation to Ionising Radiation Regulations (IR(ME)R) 2017, which regulate the protection against exposure to ionising radiation due to staff roles. The protocols and procedures were reviewed and approved by a consultant radiologist and Ionising Radiation (Medical Exposures) Regulations (IR(ME)R) practitioner license holder.

Staff demonstrated they knew how to access the policies and procedures and signed to say they had read and understood them. When policies and procedures were updated, staff were advised by the manager of the change and updated policies were highlighted and discussed at team meetings.

Staff understood and followed best practice guidance including Ionising Radiation (Medical Exposure) regulations 2017 (IR(ME)R).

Good

Diagnostic and screening services

There was a quality assurance schedule. All staff were aware of the quality assurance procedures for all imaging equipment, for example the X-ray rooms, mobile X-ray and image intensifiers. We saw documentation was recorded and completed for June, July, August, September and October.

Nutrition and hydration

Staff made sure patients had enough food and drink to meet their needs and improve their health.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. A water cooler was available for patients to use in the main foyer and drinks and snacks were available in the café shop near the entrance to the hospital.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and to see if they were comfortable.

The X-ray procedures were painless, but staff monitored and checked with patients throughout the X-ray to ensure they were comfortable. Staff assisted patients to access the X-ray machine and helped position them appropriately.

No pain-relieving medicines were used within the service.

Patient outcomes

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

Managers and staff carried out a comprehensive programme of repeated national and local audits to check improvement over time. The service regularly reviewed the effectiveness of care and treatment through local audit and national audit with a structured audit programme. This enabled the service to benchmark the standard of care provided against local and national standards.

These audits included a reject analysis audit to identify any trends, such as the same radiographer or the same examination; diagnostic clinical practice review and documentation; diagnostic reference levels; diagnostics clinical evaluation of auto reported X-rays.

There was also a monthly audit of consultant evaluations of X-rays. All orthopaedic X-rays, pre, peri and post-operative were clinically reviewed by the referrer. This was in line with IR(ME)R regulations which required an appropriate clinical review by a qualified person, which in the provider's case, was the consultant orthopaedic surgeon. This review was audited monthly and actions taken as required to address any anomalies. The films were not reported by a radiologist when dealing with orthopaedic cases. Any cases that were outside of orthopaedics would be reported by a radiologist as was the case when the X-ray was not requested by a consultant.

Managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits. Action plans were developed to address areas of improvement and were regularly reviewed and reported.

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

Good

Diagnostic and screening services

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. The service made sure staff were competent for their roles.

Managers supported staff to develop through yearly, constructive appraisals of their work. All staff had received an annual appraisal. The service was 100% compliant with the annual appraisals for staff. Appraisals were conducted during the period from October to December each year with a report to the senior management presented in December.

Staff attended team meetings or had access to full notes when they could not attend. Minutes of meetings were available for staff to read.

Staff were given a full induction tailored to their role before they started work. Staff confirmed they received a comprehensive induction. They felt confident and prepared to work in the department.

Managers supported staff to develop through regular, constructive clinical supervision of their work. A mentor was also allocated to new staff and provided support with their induction programme and through their probation period. Student also received mentorship.

There was regular evaluation of radiographers' examinations.

Training needs were identified for staff and they were given the time and opportunity to develop their skills and knowledge. There was a commitment to training and education within the service. Staff told us they were encouraged and supported with training and there was good teamwork. Staff were encouraged to keep up to date with their continuing professional development (CPD) and there were opportunities to attend external training and development in specific areas. CPD folders were maintained for all staff.

The service ensured relevant staff continued to maintain registration with relevant bodies. Managers also explained if a staff member was required to submit evidence of their continuous professional development as part of their revalidation, they would be given time and support during work hours to complete this. The service held records to show the professional registration for the clinicians was checked annually with the professional body. For example, radiographers were registered with the Health and Care Professions Council

Managers identified poor staff performance promptly and supported staff to improve. Performance management was overseen centrally by the regional HR manager who supported line managers during regular visits to the hospital.

Multidisciplinary working

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

All necessary staff, including those in different teams and services, were involved in assessing, planning and delivering care and treatment. Staff ensured patients received consistent coordinated, person-centred care and support when they used, or moved between different services.

Good

Diagnostic and screening services

Care was delivered and reviewed in a coordinated way when different teams, were involved. For example, Staff contacted wards and other health care professionals to discuss any specific health care needs in preparation for the X-ray. There was an agreement where radiographers collected patients to and from the wards to X-ray during busy times.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff attended the weekly scheduling meeting to review the last week's theatre lists and the week ahead. The meeting was informative and was attended by all departments in the hospital and was chaired by the hospital director. Discussions included equipment ordered, any adjustments, for example for patients with a learning disability the bed capacity, clinical requirements and support for the ward, any alerts, for example allergies, staffing. Any gaps were identified and actions taken to address them. The attendees told us it was the most important meeting of the week and ensured patient safety both in the hospital and at home following discharge.

Staff worked closely with consultants and the Ionising Radiation (Medical Exposures) Regulations (IR(ME)R) practitioner licence holder and other designated reporters. Liaison and communication took place by telephone, email and in face-to-face meetings.

Seven-day services

Key services were available to support timely patient care.

The service provided X-rays on Monday to Friday. Radiographers were on call in the evening and at weekends to provide support and to accommodate any urgent demand.

Health Promotion

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

There was limited health promotion available to patients in the X-ray department as information provided related to the procedure being undertaken. Health promotion was a routine part of all care provided to patients in the hospital.

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.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff could describe and knew how to access the assessing capacity and Deprivation of Liberty Safeguards policy and get accurate advice in these areas. The policy set out the requirements for presuming or assessing mental capacity; documenting assessment outcomes and recording the rationale behind any decision taken on behalf of the person lacking capacity.

Staff understood how and when to assess whether a patient had the mental capacity to make decisions about their care. Staff said they were confident in making capacity assessments.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff understood how and when to assess whether a patient had the mental capacity to make decisions about their care. If staff felt a patient lacked the capacity to consent to the procedure, they would seek further advice. When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions.

Good

Diagnostic and screening services

Staff made sure patients consented to treatment based on all the information available. Staff said they obtained consent from patients prior to commencing care or treatment. They said the risks and benefits of any procedure were fully explained to the patient. During the inspection we saw staff explaining the assessment and consent process to patients.

Staff clearly recorded consent in the patients' records as we saw in all the records we reviewed.

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

Are Diagnostic and screening services caring?

Good

We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Care was delivered with kindness and patience. The atmosphere was calm and professional, without losing warmth. Staff were focused on the needs of the patients and ensured they felt respected and valued as individuals.

Staff took time to interact with patients and those close to them in a respectful and considerate way. During our inspection we observed positive interactions between staff and patients. Staff introduced themselves prior to the consultation. They were open, friendly and approachable and interactions were very caring, respectful and compassionate.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. They were knowledgeable about the framework to support communication with families who were non-English speakers, or for whom English was a second language. Support was also available for patients with hearing or visual impairment, or who had learning disabilities.

Patients said staff treated them well and with kindness. The comments we received from patients were unanimously positive. They spoke positively about their experience in the department. They confirmed all staff were kind and helpful to them.

Emotional support

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

Good

Diagnostic and screening services

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff providing emotional support to patients during their visit to the department. Patients' individual concerns were promptly identified and responded to in a positive and reassuring way.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. Throughout our inspection, we saw patients being treated with dignity and respect. Voices were lowered to avoid confidential or private information being overheard despite the difficulties of COVID-19 measures such as wearing of face masks. All patients said their privacy and dignity was maintained.

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. Patients were spoken with in an unhurried manner and staff checked if information was understood.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Patients were involved with their care and decisions taken. All 4 patients we spoke to said all procedures had been explained and they felt included in plans and were well informed.

Staff talked with patients in a way they could understand, using communication aids where necessary. We observed staff explaining things to patients in a way they could understand to help them become partners in their care and treatment.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients were able to use a friends and family test to give their feedback and recommend the service to friends and family if they needed similar treatment or care. A high proportion of patients gave positive feedback about the service in the test.

Are Diagnostic and screening services responsive?

Good

We rated it as good.

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the needs of the local population. During the Covid-19 pandemic, the hospital stopped the majority of their routine work (orthopaedic, endoscopy and general surgery) and supported the National Health Service (NHS) with additional clinics for plastics (trauma and cancer), orthopaedic trauma, breasts, urology, vascular, gynaecology, and ear nose and throat (ENT). The diagnostic team supported the delivery of these services across the hospital.

Good

Diagnostic and screening services

Facilities and premises were appropriate for the X-ray services being delivered. The environment was appropriate, and patient centred. The waiting area was located opposite the reception area and seating was available for the number of patients and relatives attending the department.

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 service had systems to help care for patients in need of additional support or specialist intervention.

Staff supported patients living with dementia and learning disabilities by using specific documents to support effective care. Staff made sure patients living with mental health needs, learning disabilities or dementia, received the necessary care to meet their needs. All staff had undertaken training in dementia awareness and were part of the dementia bus, a hospital wide project to raise awareness.

There were reasonable adjustments made so that people with a disability could use services on an equal basis to others. The access to the department and use of equipment met the needs of patients and visitors with a disability. There was car parking, including disabled parking, available on the hospital site.

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Support was available for communication with patients and carers for whom English was a second language, people with hearing or visual impairment, or who had learning disabilities. Staff could access translation services for patients through a language system. There was instant access to over 200 Interpreters who were available by phone or video and it also included British sign language available through a video link.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. For patients who were visually impaired, staff ensured an appropriate person would be able to read the safety questionnaire and consent questions and complete the form on the patient's behalf.

Access and flow

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

Managers and staff planned that patients did not stay longer than they needed to. Staff monitored waiting times and were taking actions to improve patients' access to services within agreed timeframes and national targets.

We spoke with patients who said they were satisfied with the speed of appointments and waiting times were kept to a minimum.

During the period from 1 October 2021 to 30 September 2022 there were 5,356 plain X-rays and 184 fluoroscopy imaging. There was no direct access imaging. These figures included NHS and private patients.

Good

Diagnostic and screening services

MRI scans were provided by an external medical charity providing diagnostic imaging through a mobile MRI scanner that visited the hospital site on Mondays. Staff booked patient appointments for the scans. During the period from 1 October 2021 to 30 September 2022 there were 183 scans.

A ward X-ray form had been introduced which was taken to the outpatient department each day and signed off by a consultant. This had streamlined the review process.

The diagnostic team checked the pre-operative theatre lists to ensure consultants had the latest X-rays prior to surgery. Staff also attended the weekly scheduling meeting to review the last week's theatre lists and the week ahead.

There was an agreement where staff collected patients to and from the wards to X-ray during busy times.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. Patients said they felt they could raise concerns with the clinical staff they met. Most patients told us if any issues arose, they would talk to the head radiographer.

The service clearly displayed information about how to raise a concern in patient areas. Information about making complaints was available in the department and on the website with links about how to resolve concerns quickly and how to make a complaint.

Staff understood the policy on complaints and knew how to handle them. There were policies and processes to appropriately investigate, monitor and evaluate patient's complaints. The policy stating the roles, responsibilities and processes for managing complaints. Complaints were initially responded to within 3 days by telephone or email depending on patient preference, and a full response was sent by the interim hospital director within 21 days. There was weekly contact with the complainant to advise progress.

All staff we spoke with were aware of the complaints system and the service provided. They were able to explain what they would do when concerns were raised by patients. They said they would always try to resolve any concerns as soon as they were raised, but should the patient remain unhappy, they would be directed to the manager or the complaints' process.

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. Every complaint and concern would be reviewed to identify the issues raised by the complainant to ensure learning and continuous improvement.

There were no complaints about the diagnostic service during the period from November 2021 to October 2022.

Are Diagnostic and screening services well-led?

Good

We rated it as good.

Good

Diagnostic and screening services

For our main findings on this key question please refer to the well-led section of the surgery report.

Leadership

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

Leaders had the skills, knowledge, experience and integrity to run the service. The leadership consisted of the radiology manager who reported to the head of nursing and the hospital director.

Leaders understood the challenges to quality and sustainability and could identify the actions needed to address them. They had the right skills and abilities to run the service providing high quality and sustainable care. They were an experienced and strong team with a commitment to the patients who used the service, and to their staff and each other. It was an integrated and strong team with an emphasis on providing consistent and high-quality care.

The team were knowledgeable and passionate about the service and actively worked to improve delivery of care. They were visible and available to staff, and we heard about support for all members of staff in the department.

Staff told us leaders were visible and approachable. They felt able to openly discuss issues and concerns with senior staff and their manager. They believed they would be listened to, and actions taken when necessary if anything needed to change or be addressed.

Staff were supported to develop their skills and competencies within their roles. We received consistently positive feedback from staff who had a high regard and respect for their managers.

All staff we met said they felt valued and part of the team and were proud to work in the team. They felt supported by their manager and their colleagues.

Vision and Strategy

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

There was a realistic strategy for achieving the priorities and delivering good quality sustainable care. Services had been planned to meet the needs of the relevant population. The service charter had built services around 4 key principles of good customer service: that they were personalised, competent, convenient and proactive. For the diagnostic service the team were encouraged by the senior management team to develop the service and had been involved in the business case for the new X-ray equipment and were keen to develop new services, for example MRI services and Doppler scanning.

Progress against delivery of the strategy was monitored and reviewed.

There was a clear vision and a set of values including quality and sustainability. The vision, values and strategy had been developed in collaboration across the organisation, people who used services and external partners. Staff knew and understood what the vision, values and strategy were, and their role in achieving them.

Good

Diagnostic and screening services

Culture

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

Staff felt supported, respected, valued and were positive and proud to work in the organisation. There were cooperative, supportive and appreciative relationships among staff. Staff worked collaboratively, shared responsibility and resolved conflicts quickly and constructively. The team provided support to each other. It was clear their work was important to them and they felt passionate about their contribution to care and were committed to improving the health of local patients.

The culture encouraged openness and honesty at all levels within the organisation, including people who used services, in response to incidents. Staff said learning and action taken was shared when a never event, serious incident, or near miss occurred.

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

There were mechanisms for providing all staff at every level with the development they needed, including high-quality appraisal and career development conversations through.

There was a strong emphasis on the safety and well-being of staff. Equality and diversity were promoted within and beyond the organisation. Staff, including those with protected characteristics under the Equality Act, felt they were treated equitably.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution, and appropriate learning and action was taken because of concerns raised. Staff were aware they could raise concerns about patient care and safety, or any other anxieties they had. Staff said they were encouraged to speak up and felt comfortable about raising any concerns.

Staff were aware of the whistleblowing policies and procedures and felt able to approach managers to raise any concerns or suggestions and were confident they would be listened to and action taken.

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

Governance

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

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. All levels of governance and management functioned effectively and interacted with each other. There were department meetings, heads of department meetings, quality and governance meetings. Meetings looking at operational performance and included a review of incidents reported, complaints, audit, clinical

outcomes, infection control, risks identified on the risk register and risk management, delayed discharges, cancellations, unexpected transfers, returns to theatre, readmissions training and service improvements. The meetings were minuted and the actions required were monitored with details of the person responsible for those actions and a review date.

In addition, diagnostic leads across the group met quarterly to discuss performance and themes.

Staff at all levels were clear about their responsibilities, roles and accountability within the governance framework. There was a clinical governance day for all staff every other month with an emphasis on training and learning.

An extensive set of policies was readily available on the intranet and was supported by standard operating procedures and processes. They were reviewed regularly and updated in line with national guidance and legislation.

Medical physics support was provided by the local NHS trust. Staff were clear on who their radiation protection advisor and medical physics expert were and could describe how to contact them.

Management of risk, issues and performance

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

The hospital was part of the organisation's assurance systems and performance issues were escalated through clear structures and processes.

There were processes to manage current and future performance which were reviewed and improved through a programme of clinical and internal audit. The service took part in a programme of clinical and internal audit to monitor quality and operational issues. Performance data and quality management information was collated and examined to look for trends, identify areas of good practice, or question any poor results. Staff were kept informed of audits, themes and safety issues through regular team meetings.

Leaders monitored quality, operational and financial processes and had systems to identify where action should be taken. The impact on quality and sustainability was assessed and monitored. There were no examples of where financial pressures had compromised care.

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. The service had a risk register which clearly identified individual risks and the action taken to mitigate the risks. The position was monitored at monthly meetings. There was alignment between recorded risks and what staff said was 'on their worry list'.

The risks relating to the diagnostic service included: using equipment that produced ionising radiation, obstructions at the emergency exit corridor, the hazards of using the mobile X-ray, trips, slips and falls in the viewing rooms and store room, VDUs and castors in the administration office, patient confidentiality and manual handling documents.

The service had back up emergency generators in case of failure of essential services.

Good

Diagnostic and screening services

Information Management

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

Information was used to measure improvement, not just assurance. Quality and sustainability both received coverage in relevant meetings with the organisation.

Staff had access to information they required to provide good patient care. Staff we spoke with were familiar with the systems and knew where to find the information they needed. The service had an established electronic information and patient record system. Confidentiality was maintained, and staff had access to the general data protection regulation policy.

Staff demonstrated how easy it was to pull data from the system and could present this in several formats to help with understanding and analysis of the unit's day-to-day running.

There were clear service performance measures, which were reported and monitored with effective arrangements to ensure the information used to monitor, manage and report on quality and performance was accurate. Quality information was collated through patient and staff surveys, clinical audits, service reviews and key performance indicators.

Engagement

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

Patient's views and experiences were gathered and acted on to shape and improve the services and culture. The department used a tablet with access to the friends and family test to allow patients to report on their experience. From May to October 2022, data showed a 99% to100% satisfaction rate with all patients experiencing a good service. Responses were shared with all staff in departments. Staff received this as positive feedback but also took on board any negative comments that helped to improve the service. Feedback was used to evaluate the service and the feedback we reviewed was unanimously positive.

A patient forum meeting was held twice a year where new and ex-patients were invited to attend to discuss potential service developments and improvements.

Staff were also actively engaged, including those with a protected characteristic, so their views were reflected in the planning and delivery of services and in shaping the culture. Staff told us they felt engaged, informed and up to date with what was happening within the department and the wider organisation. Information was shared through different forums. These included emails and staff meetings. Staff said they were encouraged to speak up and voice their suggestions and solutions.

Staff had access to health and wellbeing services. There was a well-being champion who was available on site to provide a listening ear.

There were several award schemes including: employee of the month and medical professional of the year. Staff received a number of benefits including bonuses in February, 2 free lunch passes per month chocolate gifts at Easter and Christmas, birthday cards and free car parking on site or at a nearby site.

Staff meetings were held each month. Staff told us a variety of things were discussed including serious incidents and key messages from the senior management team.

Learning, continuous improvement and innovation

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

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

Staff regularly took time out to work together to resolve problems and to review individual and team objectives, processes and performance which lead to improvements and innovation.

There were systems to support improvement and innovation work. The team was working towards a quality standard for imaging accreditation. The process had just begun and was being rolled out across the organisation to standardise and develop services. Information was currently being gathered.

There was planned continuous development of the unit by exploring opportunities to promote the development of different types of scans to improve patient experience and provide opportunities for staff development.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury Surgical procedures	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose Intravenous medicines were not stored securely in accordance with national guidance.

Regulated activity	Regulation
Treatment of disease, disorder or injury Surgical procedures Diagnostic and screening procedures	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider did not have a robust system to respond to concerns about a person's fitness to practice. Where a person's fitness to carry out their role was being investigated, appropriate interim measures were not taken to minimise any risk to people using the services. A risk assessment was not completed to evidence rationale, decisions and actions. Information was not shared with the location.