

Spire Healthcare Limited

Spire Southampton Hospital

Inspection report

Chalybeate Close
Southampton
SO16 6UY
Tel: 02380775544
www.spirehealthcare.com/southampton

Date of inspection visit: 08 July 2021
Date of publication: 13/09/2021

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

Ratings

Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

Overall summary

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

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care to patients. 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.
- 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 the communities it served, took account of patients' individual needs, and made it easy for people to give feedback. People accessed the service when they needed it and did not have to wait too long.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service

Critical care

Rating

Good



Summary of each main service

Our rating of this service improved. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. The care and treatment provided by the critical service supported very effective outcomes for cardiac surgery. 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.
- 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 the community they served, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- 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.

Summary of findings

Staff were clear about their roles and accountabilities. The service engaged well with and all staff were committed to improving services continually.

However:

- Some staff were not clear about the application of the Mental Capacity Act in the critical care setting.
- Although patient records were complete, signed and dated, the name of the staff member completing the entry was not always legible.
- There were shortfalls in the environment of the unit, which had an impact on equipment storage, relatives' facilities, and meant sharing a sluice with the recovery area.

Diagnostic imaging

Good



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

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well.
- Staff provided good care to patients. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, 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 the communities it served, took account of patients' individual needs, and made it easy for people to give feedback. People accessed the service when they needed it and did not have to wait too long for a diagnostic procedure.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt

Summary of findings

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 to plan and manage services and all staff were committed to improving services continually.

However

- The service managed incidents, but did not always share lessons from them in a way that gave assurance staff had reviewed it.

We rated this service as good because it was safe, effective, caring and responsive, and well led.

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Summary of this inspection

Background to Spire Southampton Hospital

Spire Southampton Hospital is operated by Spire Healthcare Limited. The hospital opened in 2007 and was registered with CQC in 2010. It is a private hospital in Southampton, Hampshire. The hospital primarily serves the communities of South Hampshire. It also accepts patient referrals from outside this area and has some national contracts in place. The service also accepts international referrals for some complex surgeries. Patients were either self-funded, insurance funded or funded by the NHS through contractual agreements to carry out NHS work. The hospital has 67 inpatient beds provided across four inpatient wards, a critical care unit and day care unit. The hospital also provides an oncology suite. There are six operating theatres, an endoscopy suite and a cardiac catheter lab. The outpatient department includes 16 consulting rooms, three treatment rooms and a minor operations suite.

Diagnostic imaging includes x-ray, ultrasound, digital mammography screening, computerised tomography (CT) and magnetic resonance imaging (MRI) scans. The critical care service at Spire Southampton was a seven bedded unit and provided care and treatment for patients following elective surgery, which was a mix of cardiac and general surgery. Children were no longer admitted to the critical care unit, and the hospital had stopped carrying out surgery that would require a child to need critical care postoperatively. The registered manager has been in post since 2019.

The hospital is registered to provide the following regulated activities:

- Surgical Procedures
- Treatment of Disease, Disorder or Injury
- Diagnostic and screening services
- Management of supply of blood and blood derived products
- Family Planning

The hospital had a comprehensive inspection carried out in July 2019, following this the service was given a requirement notice in Critical Care.

How we carried out this inspection

During the inspection, we inspected the following core services: Critical Care and Diagnostic Imaging. We spoke with 25 staff including registered nurses, health care assistants, administrative staff, radiographers and departmental managers. Due to the Covid-19 pandemic we only spoke with 2 patients, and also reviewed patient feedback. During our inspection, we reviewed 6 sets of patient records. There were no special reviews of the hospital ongoing by the CQC at any time during the 12 months before this inspection. This was a focused unannounced inspection.

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

Outstanding practice

We found the following outstanding practice:

Summary of this inspection

- The care and treatment provided by the critical care service supported very effective outcomes for cardiac surgery. Adult cardiac surgical outcomes had a survival rate higher than expected, first time, they had the shortest length of stay for first time coronary artery bypass graft surgery in the UK, they had lower surgical site infections for coronary artery bypass grafts with none reported in 174 operations over 12 months and had short waiting times between angiogram and operation date for coronary artery bypass graft surgery.
- Patients thought staff went the extra mile and their care and support exceeded their expectations. The critical care unit's patient feedback between January to June 2021 was overwhelmingly positive about how all staff responded to their needs. Patients described that staff were attentive and that nothing was too much trouble for them. In the feedback patients described that staff went the 'extra' mile to provide their care.

Areas for improvement

We told the service that it should take action because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

Critical Care

Action the service SHOULD take to improve:

- The service should ensure that all patient records are legible, including the name of the member of staff completing the record. (Regulation 17(2)(c))
- The service should ensure that all staff have a good understanding about the application of the Mental Capacity Act in the critical care setting. (Regulation 11(1))
- The service should consider continuing with their plans to redevelop the critical care unit to meet the needs of patients and staff and to meet current guidance.

Diagnostic Imaging

Action the service SHOULD take to improve:

- The service should ensure the completion of the diagnostic imaging equipment replacement project. (Regulation 12, 2 (b))
- The service should consider how it is assured staff have reviewed information from incidents.
- The service should consider how they assure themselves staff are accessing up to date policies and guidelines.






Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Critical care	Good	Good	Good	Good	Good	Good
Diagnostic imaging	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Critical care

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

Are Critical care safe?

Good 

Our rating of safe improved. We rated it as good.

Mandatory training

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

Nursing staff received and kept up-to-date with their mandatory training. Records showed 95% completion of all required courses. Staff said it was easy to access mandatory training, which was provided both electronically and by face-to-face training for practical skills.

Medical staff received and kept up-to-date with their mandatory training. Most medical staff completed mandatory training at their main place of employment. The service checked medical staff mandatory training, through the review of practicing privileges process. The resident medical officer completed mandatory training through the agency they were employed from.

The mandatory training was comprehensive and met the needs of patients and staff. Records showed mandatory training covered essential subjects such as moving and handling, compassion in practice, equality and diversity and health and safety awareness.

Managers monitored mandatory training and alerted staff when they needed to update their training. Completion of mandatory training was monitored electronically. The unit manager accessed these records to monitor staff completion and alert staff when refresher training was due.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Critical care

Nursing staff received training specific for their role on how to recognise and report abuse. Records showed nursing staff completed training about safeguarding adults and children. The level of training staff completed met national guidance.

Medical staff received training specific for their role on how to recognise and report abuse. Most medical staff completed safeguarding training at their main place of employment. The service checked medical staff safeguarding training, through the review of practicing privileges process. The resident medical officer completed safeguarding training through the agency they were employed from.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Discussion with staff demonstrated a good understanding about safeguarding adults and children. This included how to identify adults and children at risk of, or suffering harm from abuse or neglect.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service displayed flow charts in the unit to guide staff about who to inform and how to make a referral if they had a safeguarding concern about an adult or child. Discussion with staff showed they knew where to access the flow charts and knew who they needed to report any concerns to.

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 the premises visibly clean and now kept equipment visibly clean.

The critical care unit was clean and had suitable furnishings which were clean and well-maintained. The environment and equipment were visibly clean on the day of the inspection. Infection prevention and control environment audits showed the unit was cleaned to the set standards all the time.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff followed a schedule for cleaning bed spaces, equipment and the general environment. Audits demonstrated staff adhered to the schedule.

Staff followed infection control principles including the use of personal protective equipment (PPE). There was guidance and training for staff about the use of appropriate personal perspective equipment. Hand gel was available throughout the unit. This included at all bed spaces, administration areas, equipment storage areas and at the entrance to the unit. The service displayed signs at the entrance to the unit that requested all people entering the unit to sanitise their hands with gel. Observation demonstrated staff followed infection control guidance.

National guidance was followed, including routine testing of patients prior to admission, routine testing of staff and provision of PPE to reduce the risk of transmission of COVID-19. Patients were not allocated to the one side room: this was kept available to accommodate any patient who started to exhibit signs and symptoms of COVID-19 or any other transmissible infection.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. All equipment had 'I am clean' stickers on them detailing the date staff cleaned them. This showed that staff now left equipment no longer than a week between each clean.

Environment and equipment

Critical care

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

Patients could reach call bells, however they rarely needed to use call bells. Staffing levels meant staff continually observed patients and responded promptly to verbal and non-verbal requests for assistance.

The design of the environment did not follow the current national guidance and the age of the unit meant there was no requirement for the service to meet the current national guidance. Managers and staff were aware of environmental shortfalls and acted to reduce risks this might pose to patients. This had an impact on the storage of equipment, having to share sluicing facilities with the recovery area and relatives' facilities. They now had a formal plan to redevelop the critical care unit, so the current national guidelines would be met. The environment of the unit now did not have to meet the needs of children because a childrens critical care service was no longer provided by the hospital.

Staff carried out daily safety checks of specialist equipment. Records showed staff consistently carried out daily safety checks of emergency equipment and bedside equipment. Staff also checked bedside equipment before the admission of a patient.

The service had some facilities to meet the needs of patients' families. Families and relatives could use a relative's room and a spiritual room. However, this was in the adjoining day case unit and not within the critical care unit. Staff had identified this was not ideal and had included improved relatives' facilities in the proposed plans for redevelopment of the critical care unit.

The service had enough suitable equipment to help them to safely care for patients. Equipment, including specialist equipment such as emergency sternotomy equipment, was available. Processes were in place and followed by staff to ensure equipment was safe to use. Staff disposed of clinical waste safely, in line with guidance.

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.

On the critical care unit, staff identified deteriorating patients and escalated them appropriately. Staff continuously observed patients and identified changes in their conditions. Staff escalated deteriorating patients to the resident medical officer for critical care and to the on-call intensivist. Staff had immediate access to specialist equipment, such as sternotomy and resuscitation equipment, to respond to patient deterioration promptly. A service level agreement and NHS contractual agreements supported prompt transfer of patients to the acute NHS critical care services if needed.

The critical care unit had a follow up service that staff on the general wards escalated deteriorating patients to. The follow up service, which was an identified critical care nurse on each shift, gave clinical advice and support in collaboration with the resident medical officer for the hospital.

Staff completed risk assessments for each patient on admission and reviewed these regularly. Patient records included assessments of patient risks, which included risk of pressure ulcers malnutrition, venous thromboembolism, and infections. Patient records prompted staff to complete risk assessments and to review them at least three times in a 24-hour period.

Critical care

Staff knew about and dealt with any specific risk issues. For example, staff followed a sepsis care pathway way based on the national sepsis six care bundle for patients assessed at risk of potentially having sepsis.

The service did not have formal 24-hour access to mental health liaison and specialist mental health support. If staff were concerned about a patient's mental health, a referral was made to the nearby acute NHS trusts mental health liaison service.

Staff shared key information to keep patients safe when handing over their care to others. Staff followed a structured process to hand over care to the general wards when a patient was discharged from the critical care unit. This ensured the receiving staff had all relevant information such as patients' medical history, current physical conditions and any anxieties the patient was experiencing.

Shift changes and handovers included all necessary key information to keep patients safe. Staff knew about the top risks for patients on the unit and detailed information about the patients they were caring for. This was achieved through safety huddles where the top risks were shared, and through nurse to nurse bedside handovers where detailed information about the patient's care was shared.

Nurse staffing

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

The service now had enough permanent nursing and support staff to keep patients safe. The manager had recruited more nurses. The service no longer relied on agency staff and rarely used bank nurses to make up numbers. Patients said there were enough staff to provide their care and treatment.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Staffing levels and skill mix now met national guidance. There were 62% of staff who held a post registration qualification in critical care nursing. Patients were looked after by nurses who had the appropriate skills and experience.

The ward manager could adjust staffing levels daily according to the needs of patients. Staffing rotas were organised against planned admissions to the unit and were adjusted according to any change to the planned admission list. Staff said there were always enough staff on duty.

Managers limited their use of bank and requested staff familiar with the service. The service now did not use agency staff. They used a small number of bank nurses who knew the service well.

Managers made sure all bank staff had a full induction and understood the service. The service provided bank staff with induction and mandatory training. There was an induction process for agency staff, but this was not used because the service did not use agency staff.

Medical staffing

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

Critical care

The service had enough medical staff to keep patients safe. There was a critical care resident medical officer on duty 24 hours, seven days a week. The unit had an on-call consultant cardiac intensivist and an on-call consultant general intensivist 24 hours seven days a week. An on call cardiac intensivist remained on site overnight following cardiac surgery lists. Staff said they could always access medical support when needed. Processes now ensured there was a record that medical staff reviewed patients twice a day.

Managers could access locums when they needed an additional residential officer staff. The hospital had a contract with an agency for the provision of resident medical officers. The service could access additional resident medical officers through the agency if needed to ensure patient safety.

Managers made sure locums had a full induction to the service before they started work. The resident medical officers completed an induction to the service when they started working on the unit. This was confirmed in conversation with the resident medical officer.

Records

Staff kept detailed records of patients' care and treatment. Records were up to date, stored securely and easily available to all staff providing care. However, the names of people completing records were not always clear.

Patient notes were comprehensive, and all staff could access them easily. Staff completed patient records, including risks, records of care and treatment provided and communication with patients their relatives. Records were mostly legible, signed and dated. However, although always signed by the member of staff completing the entry, the name of the member of staff was not always clear.

When patients transferred to a new team, there were no delays in staff accessing their records. Patients records were paper based and travelled with the patient during their treatment journey, including discharge from the critical care unit to the general wards. Staff completed transfer notes and accompanied the patient to the place of discharge, including transfers to NHS providers, to ensure accurate handover of records and patient care and treatment information.

Records were stored securely. Patient records were stored at the bed space of each patient, so staff had immediate access to them. The service assessed this as secure: records were always in sight of staff and access to the unit was restricted by a swipe access door.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines records were complete and contained details on dose, when patients received them, and controlled drugs were double checked.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. A pharmacist who had a specialist interest in critical care checked patient's medicines and prescriptions daily. They gave advice to prescribers, particularly when patients prescriptions changed. They had introduced changes to the prescriptions chart to reduce risk of medicine errors when patients' prescriptions changed following cardiac surgery.

Critical care

Staff stored and managed medicines in line with the provider's policy. Staff followed a process that ensured enough stock of medicines. All medicines were stored safely in locked cupboards.

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

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. 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. They described the type of incidents reported and how to report them. This included reporting serious incidents, concerns and near misses. The hospital incident reporting policy gave staff guidance about reporting incidents.

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. The incident reporting system and investigation process supported staff to assess and identify if the duty of candour process needed to be followed. Incident investigation reports demonstrated staff followed the duty of candour process.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff acted promptly to implement any required changes as a result of incidents. Safety briefings on the unit and briefings supplied by the provider gave staff timely information about incidents that occurred both at the hospital, across the Spire Healthcare locations and across other national healthcare providers. This process also supported implementation and review of actions from patient safety alerts in a timely manner.

Staff met to discuss the feedback and look at improvements to patient care. They discussed lessons learned at staff meetings and safety briefings. This was recorded in the unit's newsletters, records of staff meetings and was displayed on the staff notice board.

There was evidence that changes had been made as a result of feedback. This included, following an incident where the controlled drug keys were mislaid for a short period of time, relocation of the controlled drugs cupboard and brightly coloured lanyards attached to the medicine and controlled drug keys for easy identification of them.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff followed a clear process for investigating incidents. Records of incident investigations demonstrated patient and family wishes and questions were included in the process.

Safety Information

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

Critical care

The service continually monitored safety performance and data was displayed on the unit for staff and patients to see. This data included number of falls, pressure ulcers and urinary tract infections.

Are Critical care effective?

Good 

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies and procedures reflected national guidance and staff had easy access to them electronically. Staff delivered care and treatment in line with national standards where practicably possible. The service had completed a gap analysis of how it was or was not meeting the national intensive care standards. Where practicable they had introduced changes, for example the nurse educator role, introduction of and training about local safety standards for invasive procedures and stopping treating children on the unit, to meet the national standards. Where currently not practicable to meet the national standards, for example the unit's environment, the service was in the initial phases of planning to improve the environment to meet the current standards.

Managers checked to make sure staff followed guidance. Audits, for example records audits and hand hygiene audits, were used to monitor that staff followed guidance and where needed managers acted to ensure staff followed guidance.

Nutrition and hydration

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

Staff made sure patients had support with nutrition and hydration to meet their needs. Due the nature of the service provided patients rarely required specialist feeding or hydration techniques. The hospital provided meals suitable for people's dietary needs such as vegan, lactose free and for religious and cultural needs, such a Halal meal.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Patient records showed staff completed fluid intake and output records for all patients.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Critical care staff now completed nutritional assessments for all patients on the unit.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Due the nature of the service provided, specialist support for patients was rarely needed. When assessed as required, staff accessed dietetic support for patients from the hospital dietitian. Speech and language therapy support was sourced though referral to the acute NHS trust.

Critical care

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. Patient records included pain assessments. Staff used a variety of tools to assess whether patients had pain, which included verbal and non-verbal assessments of pain.

Patients received pain relief soon after it was identified they needed it or they requested it. Patients said they received pain relief and experienced no pain.

Patient outcomes

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

The service participated in some relevant national clinical audits. The hospital reported its cardiac surgery outcomes to the Society for Cardiothoracic Surgery (SCTS) and the Institute for National Centre for Cardiovascular Outcomes Research (NICOR). The survival rates were 'risk adjusted' to consider the illness of the patient and the complexity of the operation. The service did not currently report outcomes to the Intensive Care National Audit and Research Centre (ICNARC). However, the service did now collect and analyse similar data to that which would be submitted to ICNARC.

The care and treatment provided by the critical care service supported very effective outcomes for cardiac surgery. Adult cardiac surgical outcomes for March 2017 to February 2020 demonstrated a survival rate higher than expected. Public Health England identified that Spire Southampton had significantly lower surgical site infections for coronary artery bypass grafts with none reported in 174 operations over 12 months. The hospital had the shortest length of stay for first time coronary artery bypass grafting surgery in the UK. The 2020 National Institute for Cardiovascular Outcomes Research report showed that the length of stay for first time coronary artery bypass grafting surgery was the lowest on the UK for the last three reported years. The hospital had consistently short waiting times between angiogram and operation date for coronary artery bypass grafting surgery. The latest data (2018/2019) showed the hospital had the fifth shortest waiting time in the country.

Data collected by the service showed outcomes for patients, including those not undergoing cardiac surgery, were positive and they mostly met national recommendations.

Managers and staff used the results to improve patients' outcomes. Where the service did not meet compliance with elements of audits, an action plan was developed to check improvement. Improvement was monitored and action plans updated when compliance was met.

The service had a lower than expected risk of readmission for elective care than the England average. In the three months prior to the inspection five of 142 patients admitted electively to the unit were readmitted within 48 hours.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment. Staff completed a variety of clinical and environmental audits to provide assurance about local practice in their areas.

Critical care

Managers shared and made sure staff understood information from the audits. Discussion of audit results were included during regular team meetings so that staff understood information and associated required improvements from the audits.

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. Out of the 21 nursing staff, 13 had a post registration qualification in critical care nursing which met national guidance. All staff were completing national critical care competencies. This training ensured patients were cared for by a team of nurses who had the appropriate skills and experience.

Managers gave all new staff a full induction tailored to their role before they started work. New staff felt supported to carry out their new role. All new staff completed an induction programme tailored to their role. This included a supernumerary period to learn the role and training sessions.

Managers supported staff to develop through constructive appraisals of their work. Staff were supported to develop their skills. All nursing staff received appraisal of their work twice a year from the manager.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Most consultants had their main place of employment within acute NHS trusts and had their work appraised there. Medical staff had their work appraised in their main place of employment and there was a process to share appraisal information between the service and the acute NHS trust.

The clinical educator supported the learning and development needs of staff. There was now a dedicated clinical educator for the unit. The training programme was planned around national critical care competency pathways for nursing staff and training packages tailored to meet the needs of the unit. The clinical educator empowered staff to consolidate their learning and develop skills by developing their own bite size learning packages to deliver to staff. Managers considered learning and development as essential to the effective running of the unit and gave them the time and opportunity to develop their skills and knowledge. Staff were allocated one day every two months for learning and development.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Meetings had comprehensive and easy to understand minutes. Staff received meeting minutes when they could not attend meetings.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff received regular meetings with managers to discuss their development and what skills they would like to develop. For example, two places on a critical care nursing course had been secured. The manager and clinical educator were encouraging those staff who wanted to progress their career to apply for the course.

Managers made sure staff received specialist training for their role. Cardiac surgery advanced life support training was completed by nursing staff.

Multidisciplinary working

Critical care

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 service ensured necessary staff were involved in assessing, planning and delivering care. Patients had routine access to physiotherapists and pharmacists. Access to other health professionals, such as dieticians and speech and language therapists were arranged as required.

Staff worked across health care disciplines and with other agencies when required to care for patients. The service worked collaboratively with the local NHS acute trust to share care and treatment of patients. During the COVID-19 pandemic Spire Southampton Hospital had supported the local NHS acute trust with complex surgery. This had meant the acute NHS teams had worked alongside the staff from Spire Southampton hospital, including staff working in the critical care service. Staff reported they had worked as a single team to provide safe and effective care and treatment to patients. Patients could access services from other organisations through service level agreements. Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. Staff knew how to refer patients to the local NHS mental health services.

Seven-day services

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

Staff on wards could call for support from the critical care follow up service seven days a week. A member of the critical care staff was allocated on each shift to follow up patients who had recently been discharged from the unit. They also responded to calls for assistance and advice from the general wards about deteriorating patients.

Patients were reviewed by consultants twice a day. A relevant consultant (cardiac intensivist or general intensivist) reviewed patients on the unit twice a day and this was now recorded. A cardiac and general intensivist provided 24 hour seven days a week on call service for patients. They attended the hospital within 30 minutes if the patient required their attention. The resident medical officer was available on site 24 hours seven day a week.

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. They had an understanding about the use of agreed personalised measures that limit patients' liberty appropriately. However, some staff were not clear about the application of the Mental Capacity Act in the critical care setting.

Not all staff understood how and when to assess whether a patient had the capacity to make decisions about their care. During conversations some staff demonstrated a lack of full understanding about how the mental capacity act and assessing patient's mental capacity to make specific decisions applied to patients in the critical care setting. Managers had identified staff understanding about the application of the mental capacity act in the critical care setting was not robust and had plans to address the knowledge gaps.

Staff made sure patients consented to treatment based on all the information available. Patients felt well informed to give consent. The consent process ensured patients fully understood the surgical procedure, risks associated with it and the reason for admission to critical care. Consent to procedures was recorded in patients' records.

Critical care

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Out of 34 members of staff, 33 had completed mental capacity and Deprivation of Liberty Safeguards training.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Detail about the Mental Capacity Act and Deprivation of Liberty Safeguards, including a flow chart about how to apply for a deprivation of liberty safeguard authorisation, was displayed on the staff notice board. Staff knew how to access policies and procedures about the Mental Capacity Act.

Are Critical care caring?

Good 

Our rating of caring improved. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Patients thought staff went the extra mile and their care and support exceeded their expectations.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff interacted with patients a respectful and discreet way. Staff were responsive to patients requests, for support and help. The critical care unit's patient feedback between January to June 2021 was overwhelmingly positive about how all staff responded to their needs. Patients described that staff were attentive and that nothing was too much trouble for them. In the feedback patients described that staff went the 'extra' mile to provide their care.

Staff respected the dignity and privacy of patients. They reminded others working on the unit to speak in quiet voices when patients were trying to rest and sleep. Staff now made sure curtains were fully pulled around the bed areas to provide privacy when needed. This ensured patients' dignity was always maintained whilst personal and clinical care was being provided.

Patients said staff treated them well and with kindness. One patient said staff went out of their way to make them feel 'comfy and safe, and they could not have felt more safe and looked after.' A second patient said they remembered staff talking with them and always being there for them.

Feedback from people who used the service, those who were close to them was continually positive about the way staff treated people. The hospital's patient feedback between January to June 2021 included large numbers of comments about staff kindness and feeling safe. Of 163 patients who gave feedback 85% said the service was very good and 13% said it was good. Three patients (2%) could not comment as they did not have any memory of their admission to the unit. One patient commented, "What impressed me the most was that nurses would come up and ask me if there was anything they could do for me, I have never had this experience in a hospital before – I thought they were amazing." Other comments included, "They made me feel special," and "I was looked after like a millionaire."

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 considered patient's personal needs and

Critical care

wishes. Patient feedback from the critical care unit's surveys showed patients felt they were treated as an individual. Comments included, "They also made time to talk and were genuinely concerned and interested", "They were interested in me, as an individual not just as a patient, I was not treated as a piece of impersonal machinery in for repair" and "I had some interesting conversations with them which helped me to feel positive."

Discussion with staff demonstrated an understanding about meeting the needs of patients with mental health needs. They knew how to access advice and support by referral to mental health services if needed.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. An example was shared about how the service had supported a patient who was recognised as being at end of life to decide about where they wanted to die. The service sought the support of the hospital's oncology team who had specialist skills to discuss such issues. The service also recognised the importance of family in these circumstances, allowing family to be with the patient despite current pandemic restrictions.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff recognised the emotional impact being in critical care might have on patients and provided relevant support. The critical care unit's patient feedback between January to June 2021 included large numbers of comments about how staff had reduced the fear and anxieties of patients. One patient commented that a critical care nurse came to see them on the general ward prior to surgery to explain to them to what expect in the critical unit following, they found this reduced their anxieties. There were comments about how staff had communicated with patient's relatives, updating them about their condition and treatment. This, patients said, reduced anxieties for both them and their relative. Many patients described how staff of all roles (physiotherapists, doctors, housekeeping and nursing staff) reassured them. One patient said they made me "feel at ease at such a frightening time."

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff had an awareness of the emotional needs of patients, including the additional needs associated with the effect of patients not receiving visitors due to the current COVID-19 pandemic.

Staff were mindful of the emotional impact being treated in the critical care unit might have on patients. Staff provided ongoing support, including emotional support, through the critical care follow up team when patients were discharged back to the wards. Although currently there was no formal critical care follow up programme once patients were discharged from hospital, staff were supportive of patients that wanted to come back to visit to understand their care.

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. One patient said all staff, including medical staff and anaesthetists, explained their care and treatment in a way they understood. In the critical care unit's patient feedback between January to June 2021 patient commented about how staff explained things in a way they

Critical care

understood and how they were involved in decisions about their care and treatment. Comments included, “The surgeon explained fully about my operation and even asked what type of valve I wanted and “Communication and fact sharing was especially good”. Patients also commented about how their relatives, who could not visit them in hospital due to the COVID-19 pandemic restrictions, were kept informed about their condition and treatment, by telephone calls from staff. Fees for patients who paid for their own care and treatment were available, and these could also be requested through the service website.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service now had a process for patients to give feedback about the service. Questionnaires were sent to patients after they were discharged from the hospital, requesting feedback about their experience in the critical care unit.

Patients gave positive feedback about the service. Feedback from patient surveys gave consistently positive feedback about the service, including making the patient feel like a person and not an inconvenience, and the whole team being caring and attentive.

Are Critical care responsive?

Good 

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

Service delivery to meet the needs of the community

The service planned and provided care in a way that met the needs of the communities it 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 community served. The service provided care and treatment for patients undergoing elective surgery who required critical care postoperatively for a short period of time. The service did not provide an emergency service, other than accommodation and treatment for patients whose conditions deteriorated on the general wards of the hospital.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. There had been no mixed sex breaches in the unit in the past 12 months.

Facilities and premises were appropriate for the services being delivered. Due to the age of the critical care unit, it was not required to meet all the current national guidance for the environment of a critical care unit. The unit was small and did not have all the facilities a modern critical unit would have. However, staff worked hard to make the best of the environment and were able to provide safe and responsive care to patients admitted to the unit.

A further example of the impact the environment had on the service, was that the relative’s room was located away from the unit, rather than within or next to the unit.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. Although there was no mental health support provided by the hospital, staff knew how to access mental health and learning disability support through the local NHS trust mental health service. The unit had a dementia champion and all staff had completed some training about supporting patients living with dementia.

Critical care

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. 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. Staff gave examples where they had made reasonable adjustments to meet the specific needs of people. Preadmission assessment processes identified if patients needed additional resource or reasonable adjustments to meet all their needs.

The unit was not designed to meet the needs of patients living with dementia. The unit rarely provided care and treatment to people with living with dementia and currently was not designed to meet the needs of patients living with dementia. However, the unit did have a dementia link nurse and resources such as twiddle muffs for distraction and occupation, were available to support the care and treatment of a person living with dementia if they were admitted to the unit.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Patients living with dementia and learning disabilities were not frequently admitted to the critical care unit. However, if they were staff had access to information to help support the patient. Staff carrying out preadmission assessments completed 'This is me documents' for patients living with dementia and learning disabilities.

The service had information leaflets available in languages spoken by the patients and local community. These were provided to patients at their pre-operative assessment. There were minimal leaflets on the unit, due to lack of space, but information displayed about how to make a complaint was in multiple languages.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to translation services for patients where English was not their first language, and this included access to British Sign Language interpreters.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The service provided critical care for planned elective surgery, with surgery planned to make sure there was bed availability for the patient. Data showed that where a patient was admitted from the general wards, this happened within four hours of the decision to admit, which met national standards.

Managers and staff worked to make sure patients did not stay longer than they needed to. Patients typically stayed on the critical care unit no longer than 48 hours. Patients were discharged from the unit within four hours of the decision to discharge. This met national standards.

The service moved patients only when there was a clear medical reason or in their best interest. All transfers made to NHS acute services were for clinical reasons or NHS contractual reasons. There were no non-medical transfers in the past six months. This met national standards.

Critical care

Staff did not move patients between wards at night. There had been four patients discharged from the unit between the hours of 10pm and 7am in the previous six months. These were all for clinical reasons and equated to four out of 379 patients

Staff supported patients when they were referred or transferred between services. Staff explained to patients and their relatives the reasons for their transfer to the acute NHS trust. For some patients, whose treatment was funded by the NHS, the contractual arrangements that meant they may be transferred to the acute NHS service was explained during their consent process.

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. Information about how to make a complaint was available on the provider's website and displayed on posters throughout the hospital.

Managers investigated complaints and identified themes. There had been no complaints received about the critical care service in the twelve months preceding the inspection. Management of complaints was led by the hospital administrator who delegated investigation of complaints to the relevant clinical lead. Patients were involved in the complaints process, with the hospital identifying what questions patients wanted answering and the outcomes they sought from their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Feedback from complaints across the hospital was shared with all staff so learning and improvements could take place in all areas, including the critical care unit.

Are Critical care well-led?

Good 

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

Leadership

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

The critical care unit was led by a manager supported by a deputy manager. Clinical leadership for the unit was led by a general and cardiac intensivist. Senior leaders, including the head of clinical services and the hospital director, were seen regularly on the unit. Staff spoke positively about the leadership at all levels, describing the leadership as being very supportive, accessible and working well with everyone. They commented that the leadership style had improved, with the views and opinions of staff now being considered in decision making processes.

Critical care

There was a shared understanding across all levels of leadership about the priorities and issues faced in the critical care services and they took actions to address them.

Leaders supported staff to develop. Education was considered a high priority; staff were encouraged to take on 'link' roles and develop their knowledge in those areas and the unit had secured opportunity for two nurses to complete a critical care course.

Vision and strategy

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

The service had a strategy, with the overarching vision of driving excellence, which was displayed on the staff notice board.

The strategy set out how the service would deliver and monitor progress against the strategy. This included the use of audits, development of link and lead roles and introducing a governance plan.

The strategy was developed with the input of staff and the hospital wide strategy was in the process of being developed with the outputs from individual wards and units. The hospital strategy was also considering the needs of the wider health economy which included working with the acute NHS trust to meet the needs of the local community. There was a target date for completion of the hospital strategy of August 2021.

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 were positive, enthusiastic and were proud to work for the service. Staff felt supported, respected and valued; especially during the last year of the pandemic when the service had predominantly supported the NHS services. The improved education programme for staff had improved their morale and enthusiasm.

Staff focused on the needs of patients receiving care, they showed kindness and compassion towards patients.

Leaders at all levels supported the wellbeing of staff. Leaders listened and responded to staff concerns. Staff could access support resources through an employee assist programme and virtual meetings were held to support staff through the pandemic. The hospital had an established Freedom to Speak Up Guardian and ambassadors and staff knew how to contact them if they wanted to raise concerns confidentially.

The service promoted equality and diversity in daily work. The critical care work force was a supportive and diverse team with no instances of inappropriate behaviours relating to equality and diversity.

Critical care

The service showed a culture openness and honesty, staff, patients and relatives could raise concerns without fear. Staff had a good understanding of duty of candour and we saw evidence which reinforced this in incident reports.

Governance

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

Leaders operated effective governance processes that could now evidence the quality of care. There was now a clear structure for governance and sharing of information across all leadership levels and staff working in the unit. Twice daily huddles, both at senior leadership level and at unit level allowed sharing of essential safety information to all staff. Monthly team meetings and quarterly critical care delivery group meetings were recorded and reviewed performance of the service. Actions were tracked, and records showed they had been completed.

Staff were clear about their roles and accountabilities. The manager of the unit had acted to improve the governance processes, staff understood their role and a member of staff was allocated the role as governance link nurse supporting effective governance processes on the unit.

At a senior leadership level, there was now a governance lead, who had introduced effective governance processes to the hospital.

Management of risk, issues and performance

Leaders and teams now 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.

Leaders used systems to manage performance effectively. The service now had a programme of audits to monitor quality and developed action plans when results identified improvement was needed.

The service had arrangements for identifying, recording and managing risks. The service had identified risks around the environment of the unit relating to the size of the unit and the risk of limited exposure of staff to some rare procedures. These risks aligned with what staff told us they were worried about. The service had put into place mitigations against these risks to reduce their impact.

The service had a business continuity plan. This detailed the actions staff needed to take in the event of unexpected events to ensure patient safety was not affected.

Staff contributed to decision making about the management of risks, issues and performance during team meetings.

Information management

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

Critical care

The service now collected data and analysed it. Data collected and analysed provided a picture about the patient experience and the current performance of the service, which the service used to identify areas for improvements.

Staff could find the data they needed. Policies and procedures and data about performance were stored electronically and in paper format that staff could easily access.

The service had arrangements to ensure data or notifications was sent to external bodies as required. Notifications, such as serious incidents, were submitted to the Care Quality Commission.

Engagement

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

The service now gathered people views and experiences of the service to shape and improve the service. The service gathered patient feedback using feedback forms, feedback was analysed to seek improvement.

Leaders actively engaged with staff through annual staff surveys, team meetings, electronic communication, newsletters, staff notice board and in informal discussions. Staff felt their view and opinions were listened to. They could now see changes being made that addressed their views and opinions, such as the plans to redesign the critical care unit.

Leaders collaborated with partner organisations to help improve services for patients. They had a good working relationship with the local acute NHS trust. Following the successful pandemic surge work with the local acute NHS trust, new patient pathways to include additional surgery and treatments that might include admission to the critical care unit, were being developed.






Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Staff did not have a full understanding of quality improvement methods or the skills to use them.

Staff were proactive and committed to learning and improving. For example, a member of staff was researching and determining how the service could best support autistic patients. The service had introduced cardiac surgery advanced life support training to equip staff with the specialist skills to manage the deteriorating cardiac patient.

Although quality improvements were being made across the service, knowledge about quality improvements methodologies across the hospital was in its infancy. Training about quality improvement methodology was being rolled out across the hospital.

Diagnostic imaging

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

Are Diagnostic imaging safe?

Good 

Our rating of safe improved. We rated it as good.

Mandatory training

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

Managers monitored mandatory training and alerted staff when they needed to update their training. The provider set training targets, and these were monitored by managers in the service. The compliance of training was overseen by members of the senior leadership team, if targets had not been met managers were approached to identify reasons why.

Staff kept up to date with their mandatory training. New staff were required to complete training within 3 months of starting a post. Targets for training completion were set at 95%, this was currently at 96% and deadline for completion was March 2022.

The mandatory training was comprehensive and met the needs of patients and staff. Training covered areas such as manual handling, compassion in practice and infection prevention. Staff received emails alerting them when training was due to expire.

There was mandatory training in basic life support and staff who undertook cannulation had additional training in intensive lifesaving skills.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Training in these areas was part of mandatory training in a module called 'compassionate care'. In addition to this all staff undertook a face to face training session on dementia with staff who were 'Dementia Friends'.

Safeguarding

Diagnostic imaging

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.

Radiographers and support staff received training specific for their role on how to recognise and report abuse. Compliance with safeguarding training was 94% for adults and 96% for children, the target for training was 95%. Senior leaders told us how some training was unavailable due to a provider wide update at the time of inspection. Safeguarding formed part of mandatory training and this covered the patient groups of adults, children and young people. The safeguarding lead for the service facilitated face-to-face training to give staff a chance to test their knowledge and ask questions.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff provided examples of situations that may raise concern, for example unusual (or unexplained) injuries identified on x-ray images.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was a designated safeguarding lead for the location who supported departments in raising safeguarding alerts, this gave a consistent approach to reporting.

Staff followed safe procedures for children visiting the department. Children were accompanied by a parent or carer and were able to wait with them. Parents could accompany their child into the scan room and left when radiation was present.

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 visibly clean and well-maintained. Surfaces in clinical areas were cleaned and chairs wiped by staff after every use. Changing areas were cleaned between patients and were free of dust. There were clean gowns for patients to use when changing.

The service performed well for cleanliness. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Waiting areas had cleaning schedules on display and these had been completed. The service was fully compliant in environmental cleaning audits for the previous 5 months. Handwashing audits for the previous 3 months showed 100% compliance.

Staff followed infection control principles including the use of personal protective equipment. Staff followed the hospital's hand hygiene and bare below the elbow policy. There were visual guides on personal protective equipment. Staff told us what personal protective equipment they used and how this varied with clinical need.

There was adequate personal protective equipment and staff confirmed there were no difficulties in obtaining this. There were wall-mounted hand gel sanitisers readily available in all areas, there were also lower level dispensers for accessibility. Staff used aseptic procedures when cannulating patients for scans in line with national guidance.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Equipment was cleaned between patients and there was guidance on which cleaning products to use. When not in use, the ultrasound machine was labelled with 'I am clean' stickers.

Diagnostic imaging

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. In the main waiting area, a panel showed reception staff where call bells were activated, this supported staff to respond quickly when called. Changing areas had call bells, and in clinical areas they were appropriately located.

The design of the environment followed national guidance. The furniture in the waiting area supported social distancing. All information on tables had been laminated to enable wiping clean, posters on notice boards were stored in plastic sleeves. Waiting areas had music playing which reduced background noise.

Staff carried out daily safety checks of specialist equipment. Diagnostic equipment had appropriate daily and weekly checks, staff showed us these and were able to detail how they were completed. Scanning equipment had annual servicing carried out by the manufacturer and this was planned to avoid disruption.

Some of the imaging equipment was more than ten years old and at higher risk of breakdown, increased operational costs and may have reduced image quality. The service had an equipment replacement programme for the older equipment in the department and was planned to be completed within the next year.

The service had suitable facilities to meet the needs of patients' families. Due to national restrictions patients were advised to attend alone where possible. There was however enough seating to enable carers or family to attend when needed.

The service had enough suitable equipment to help them to safely care for patients. The (equipment in the) interventional radiology area was able to support the general imaging area if equipment was not in use. In MRI, mammography unit, and CT there were contingency plans if equipment was faulty or not operational.

Staff disposed of clinical waste safely. Clinical waste bins had signage that indicated what was to be disposed of in them and staff understood it. The service had recently changed the type of sharps bin they used to reusable ones, staff explained how these were collected and the differences in waste disposal for liquids and sharps. Sharps bins were closed between use to avoid spillage, labelled and stored in line with national guidance. There were audits to monitor waste management, and these showed staff were following guidance correctly.

Assessing and responding to patient risk

Staff identified, responded to and removed or minimised risks to patients. Staff identified and quickly acted upon patients at risk of deterioration.

Staff responded promptly to any sudden deterioration in a patient's health. There was mandatory training in basic life support and staff who undertook cannulation had additional training in intensive lifesaving skills .

Staff completed risk assessments for each patient on arrival, and reviewed this regularly, including after any incident. Staff reviewed referrals for imaging and these provided some details of patient risks. Staff told us these did not always give full details of risk, so they also carried out a verbal pre assessment. Access to CT and MR areas were area were controlled by secure doors.

Diagnostic imaging

Staff knew about and dealt with any specific risk issues. Staff used 'pause and check' and we saw posters supporting this in imaging areas. Pause and check is a checklist followed by radiographers for good practice in line with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). When staff administered intravenous contrast, staff completed an individual patient risk assessment to identify risk of anaphylaxis. Staff also checked records for recent blood levels of patients having contrast, to ensure this would not damage body organs.

MRI scans use strong magnets to produce images, these can affect any metal implants or fragments in the body. *Metal objects* may also interfere with the magnetic field and can cause a safety hazard. Radiographers in the MRI area ensured all staff and patients undertook a metal screening assessment before entering. Equipment was labelled to show if it was MRI safe, non-MRI safe equipment was stored in a designated area.

The service could signpost patients to specialist mental health support. The location did not provide mental health service on site. Patients needed to be referred to these services on request to their doctor or were signposted to appropriate services. Staff were supported by a safeguarding lead who could make referrals to specialist teams or private GPs.

Staff shared key information to keep patients safe when handing over their care to others. When inpatients were scanned, staff provided details of procedures and any contrast medicines to the ward. When imaging was completed scans were processed and loaded into the *picture archiving and communication system* to be viewed by consultants or radiologists.

Staffing

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

The service had enough radiographers and support staff to keep patients safe. Managers accurately calculated and reviewed the allied health professionals and support staff in accordance with national guidance. Staff rotas were completed in advance and considered factors such as pre planned leave.

New staff had been recruited to replace those that had left. Managers told us recruitment was undertaken in a way ensure there were no gaps between staff leaving and new ones starting.

Managers limited their use of bank staff and requested staff familiar with the service. Managers made sure all bank had a full induction and understood the service. All bank radiographers had previously been employed in the service as substantive staff and had undertaken a full induction as part of this. The number of bank radiographers represented less than 6% of the department staff.

Records

Staff kept detailed records of patients' care and diagnostic procedures. Records were clear, up to date, stored securely and easily available to all staff providing care. Staff always had access to up-to-date, accurate and comprehensive information on patients' care and procedures. All staff had access to an electronic records system that they could all update.

Diagnostic imaging

Patient imaging records were comprehensive, and all staff could access them easily. The department used *picture archiving and communication system (PACS)* to store and process images.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff working across providers accessed diagnostic images once post processing had been completed. Post processing involved recording the name of the operators who undertook the procedure and confirmation of the imaging performed and associated dose.

Records were stored securely. The computer systems and record programmes could only be accessed by authorised staff using a password.

Medicines

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

Staff followed systems and processes when safely administering, recording and storing medicines. When contrast was administered this was done under a Patient Group Direction (PGD). PGDs are written instructions to supply or administer medicines to patients, usually in planned circumstances.

Staff stored and managed medicines securely in line with the provider's policy. Staff labelled contrast with the date it entered the warming cabinet, this was monitored and disposed of after 28 days, this was in line with manufacturers guidance. The PGDs were in date and had been reviewed by an appropriate staff group.

Incidents

Staff recognised and reported incidents and near misses. When things went wrong, staff apologised and gave patients honest information and suitable support. The service managed patient safety incidents. Managers investigated incidents but the method used to share information with clinical staff did not support it being done in a timely manner.

Staff knew what incidents to report and how to report them. Training on reporting incidents was given to all staff and they were familiar with how to do this.

Staff raised concerns and reported incidents and near misses in line with provider policy. Managers discussed incidents with staff at the time of reporting, all incidents and near misses were reported. Staff reported serious incidents clearly and in line with policy. The service had no never events. Managers supported staff in reporting incidents to ensure consistency.

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 investigated incidents thoroughly. Patients and their families were involved in these investigations. Incidents were investigated in line with location policy and this included completing duty of candour.

Staff met to discuss the feedback and look at improvements to patient care. Senior leaders monitored improvement compliance and discussed this with leaders in the department. Staff had regular meetings where some incidents and improvements were discussed. Learning was also communicated in staff communications such as newsletters and staff notice boards.

Diagnostic imaging

Managers shared learning with their staff about never events that happened elsewhere. The service used 'flash updates' to immediately alert staff to immediate learning and changes following incidents. This method supported rapid changes to practice and patient safety.

Staff did not always receive feedback from investigation of incidents, both internal and external to the service in a timely manner. 'First Sight' folders were used to provide staff with updates and learning from incidents. The information in these folders was for staff to review and some required signing to show information had been read, but there was no timeframe attributed to when staff should have signed this by. In some instances, these were signed months later or were unsigned meaning there was no assurance information had been shared.

Are Diagnostic imaging effective?

Good 

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

The service provided care and procedures based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. However, in some areas copies of printed documents that were not the most recent version.

Staff followed policies to deliver high quality care according to best practice and national guidance. The service had policies in place to support good practice and these were available electronically. Changes in national guidance was communicated to leaders from the provider and this was implemented at the location. However, in some areas paper copies of documents were not the most recent versions. In addition to this, the service had recently supported the local health trust waiting lists by undertaking some imaging procedures and staff were using paper copies of trust policies and could not always be assured they were accessing the most recent version.

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

Nutrition and hydration

Staff made sure patients did not fast for too long before diagnostic procedures. Staff took into account patients individual needs where food or drink were necessary for the procedure.

Staff made sure patients had enough to eat and drink. There was fresh water and hot drinks were available on request. Staff were able to supply children with small snacks. Guidance was given on fasting in information given to the patient in advance. Radiographers checked this guidance had been followed when speaking with patients.

Pain relief

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

Diagnostic imaging

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

Patient outcomes

Staff monitored the effectiveness of care. They used the findings to make improvements and achieved good outcomes for patients. The service was working towards quality standard for imaging (QSI) accreditation through a provider led plan.

Diagnostic imaging reporting times were lower than the national standard in all modalities. Managers and staff used the results to improve patients' outcomes. Due to increased workload the wait for an MRI scan had increased to between 4-6 weeks for non-urgent scanning but was below the national standard. Managers had worked to lower this by increasing capacity through extended hours but the impact of this had not taken effect at the time of inspection. When single visits were not possible, reporting was completed in a timely manner to ensure results were available before the next patient attendance.

The service undertook internal audits that were monitored at provider level but did not participate in any national clinical audits. Managers and staff carried out a comprehensive programme of repeated local audits to check improvement over time. Areas audited included checks of documentation used in radiation safety and referral paperwork. These audits ensured standards of radiation safety were met consistently, and bookings were made without delay.

Improvement from audit was monitored at both provider and service level. Staff reported audit results using a provider led audit management and tracking system. This gave senior leaders oversight of audit compliance and enabled quality improvement. Managers shared information from the audits.

Managers used information from the audits to improve care and treatment. When areas for improvement were identified this was followed up at the next audit. Senior leaders monitored implementation of improvement and compliance. The service was working towards QSI accreditation through a provider led diagnostic imaging improvement and education plan.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff were knowledgeable and able to tell us about their roles. Radiographic staff had completed further education to undertake their roles. In addition to this some staff had completed post graduate education to give more in-depth knowledge to the area they were working in.

Managers gave all new staff a full induction tailored to their role before they started work. New staff had a provider led induction and a local induction to the service. Staff were provided with a competency-based pack to complete. New staff were required to complete mandatory training within 3 months of starting their role.

Diagnostic imaging

Managers supported staff to develop through yearly, constructive appraisals of their work. There were additional 6-month 'check ins' to support staff wellbeing. Staff felt appraisals were supportive and helped them in their development.

Managers supported the learning and development needs of staff. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers were proactive in requesting additional training from senior leaders. When staff identified training, they were able to discuss this with managers at any time and did not wait until appraisal to do so. The provider was in the process of developing a programme of educational meetings and peer review processes.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Meeting notes were shared with staff in a folder for access and review. Staff also received weekly bulletins giving details of changes within the hospital.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. Staff were given time in the working day to undertake training suitable to their role, when additional training was requested this was discussed with senior leaders to ensure it would be of benefit to the service. Staff who were designated as radiation protection supervisors were given the opportunity to undertake training. The service supported role extension for radiographers where this met the needs of the service.

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 worked across health care disciplines and with other agencies when required to care for patients. The service had worked collaboratively with the local NHS acute trust to share care and treatment of patients.

Patients could see all the health professionals involved in their care at one-stop clinics. Doctors in outpatient clinics requested additional diagnostic imaging, such as plain film Xray, on the same day. Breast diagnostic clinics were staffed by a multidisciplinary team (MDT) that included clinicians, radiographers, mammographers and radiographic assistants.

Diagnostic test results were available to support timely MDT decisions on cancer care, treatment plans and achieve cancer waiting time standards. Safeguarding leads had established links with specialist support services to support patients with autism, learning disabilities, dementia, and mental health needs.

Seven-day services

Key services were available seven days a week.

The service met the availability requirements for the community it served. Patients who required urgent scans could be prioritised to enable rapid diagnosis in line with national guidance. The service offered out of hours services for patients who required urgent diagnostic services.

Health promotion

Diagnostic imaging

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

The service could access relevant information promoting healthy lifestyles and support. In the waiting areas there were posters giving information on support services. Staff told us how they provided materials and information on support and health promotion services. Patients could also request their doctor refer them to other services such as smoking cessation.

Consent, Mental Capacity Act and DOLs

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

Staff understood 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.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records. Due to the nature of imaging procedures, consent was documented and gained at each attendance in line with radiation exposure legislation.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Alternative consent forms were used when patients were deemed to lack capacity to make their own decisions for diagnostic procedures.

Are Diagnostic imaging caring?

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff spoke with kindness and engaged with patients to make them feel they were being listened to. Patients had the time needed to have explanations and be prepared for their procedures. were prepared.

Staff identified an opportunity to improve the specialist knowledge in the department for supporting patients with breast cancer; and the service was actively supporting role extension in this area.

Diagnostic imaging

Patients said staff treated them well and with kindness. Patient feedback was gained after appointments and this was positive in nature. Feedback showed patients were happy with the care they received and felt it was of good quality.

Staff followed policy to keep patient care and treatment confidential. All staff to patient conversations were held in private areas and were not overheard.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff gave examples of changes in procedure they had made to support a patient's individual needs. The provider had worked with a LGBTQ+ charity and together were developing a sexual gender and identity form for patients to express their own pronouns and gender identity.

Emotional support

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

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. There was a quiet room where staff spoke with patients if they felt distressed in a clinical area. The location also had a quiet area where patients from all areas of the hospital had space for quiet reflection.

Staff recognised the emotional impact undergoing diagnostic procedures might have on patients and provided relevant support. Within mandatory training there was a module on compassionate care that gave staff information on how to support patients including those with dementia, and learning disabilities .

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff were aware of the impact undergoing diagnostic procedures had on patients and their families. Patients were given clear details of when results would be known and who to contact, this reduced anxiety while waiting for results.

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 diagnostic procedures.

Staff made sure patients and those close to them understood their care and treatment. Patients were provided with details of the diagnostic procedure by the referring clinician. Fees for patients who paid for their own care were available and could also be requested through the service website.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff were aware of reasonable adjustments that could be made to ensure patients understood the information they were given. This included providing interpreters to support medical discussions within families. Staff requested information on behalf of patients in formats such as large print, braille or other languages. We saw how patients were encouraged to ask questions about their procedures and were given an opportunity to do so.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service. Patients were contacted after all appointments to give feedback. When feedback was given, it showed that patients were happy with the care they received and felt it was of good quality.

Diagnostic imaging

Are Diagnostic imaging responsive?

Good 

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

Service delivery to meet the needs of the community

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

Managers planned and organised services, so they met the changing needs of the community it served. The service provided diagnostic imaging services to the private patients undergoing both elective and urgent care. In addition to this during the COVID-19 pandemic the service had supported the local trust by providing services and this included diagnostic imaging procedures. This enabled the trust to continue to deliver vital services to patients whose care may have otherwise been delayed.

Facilities and premises were appropriate for the services being delivered. The service was in the process of replacing older equipment and had project in place to replace all the diagnostic equipment in the by the end of 2022.

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. Breast clinics were offered as single visit assessments for patients; with mammograms, ultrasound and clinical examinations in one appointment.

Results were not always available during the single visit however were available before the next patient attendance. Diagnostic test results were available to support timely multidisciplinary team (MDT) decisions on cancer care, treatment plans and achieve cancer waiting time standards.

The service relieved pressure on other departments. Staff performed some plain film X-rays on request, this enable flow of patient review in outpatient areas and avoided multiple patient visits. Plain film X-rays are the most frequently used form of medical imaging, they show up bones and certain other tissues.

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. The service has implemented changes to support patients with dementia, this included boxes in waiting areas that included memorabilia to engage with patients. Waiting areas had undergone patient level assessment of the care environment (PLACE) and changes had been made in response to these. For example, waiting areas had clocks that had been developed to help people with dementia and learning difficulties keep track of the time and reduce anxiety.

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Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff said patients used 'This is me' documents and they had seen them in notes when they came from the ward. They were able to use these to support conversations with patients before starting a procedure. When patients from wards were accompanied by staff, this information was also verbally communicated.

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

The service had information leaflets available in languages spoken by the patients and local community. The provider had taken steps to standardise all information posters. Notice boards had posters on interpreting and information services, and this was translated into in a wide range of languages.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff were aware of how to obtain interpreters and told us they had used them. When patients were referred, staff were given details of the preferred language spoken if this was not English for interpreters to be arranged.

When it was not possible to communicate with sign language, due to radiation protection or equipment obstructing patient vision, reasonable adjustments were made including dimming lights to guide patient breathing cycles.

Staff had access to communication aids to help patients become partners in their care and treatment. The provider was developing standardised stickers that communicated additional patient needs or concerns. For example, these would say if a patient had needle phobia or had vision loss. Reception areas had hearing loops to communicate with staff. There were also posters on accessible standards and reasonable adjustments.

Patients visit from wards were able to bring communication cards to help support conversation and improve understanding by staff.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to test and from test to results were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received diagnostic imaging within agreed timeframes and national targets. Waiting times for appointments were monitored by the department manager. When waiting times for appointments increased beyond those normally experienced this was escalated to senior managers at head of department meetings. Managers and senior leaders looked to extend working hours to meet demand.

Managers monitored and took action to minimise missed appointments. Missed appointments were flagged to managers and referring clinicians to establish the cause. Managers ensured that patients who did not attend appointments were contacted.

Managers worked to keep the number of cancelled appointments to a minimum. Patients were asked about times to avoid staff booking imaging at, to ensure they would be able to attend. When patients had their appointments

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cancelled at the last minute due to equipment failure, managers made sure they were rearranged as soon as possible and booked within national targets and guidance. Routine servicing of equipment was always planned in advance to avoid disruption. The service was also able to direct patients to an alternative provider location if there was significant disruption to the service.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. When patient feedback indicated a negative experience, this was followed up by senior leaders with patients.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. There had been no complaints received about the diagnostic imaging service in the twelve months before the inspection. Patients were involved in the complaints process, the complaints process supported patients to ask questions and the outcomes they sought from their complaint. Complaint management was undertaken by senior leaders and this was escalated at meetings and with the relevant service. Complaints were discussed at the Senior Management Team meeting, the Clinical Governance Meeting and the Medical Advisory Committee, which was held quarterly. Senior leaders followed local complaint procedures and complaint data and information was reviewed monthly to ensure that process was being followed.

Managers shared feedback from complaints with staff and learning was used to improve the service. Feedback from complaints across the hospital were shared with all staff and learning and improvements took place in all areas, including the diagnostic imaging service. Learning was communicated to managers through monthly meetings. Following completion of the complaint procedures, learning briefs were also shared with all staff. These reports gave detailed of lessons learned and any incidental learning.

Are Diagnostic imaging well-led?

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

Leadership

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

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Staff said they felt leaders engaged with and listened to them. Leaders supported staff in their development and encouraged them to own their achievements both in their departments and as a wider Hospital. Leaders had an open-door policy and supported staff to raise concerns and seek out support. Staff said they felt able to approach management and discuss any concerns with them. They gave examples of when they had done this. Staff felt leadership had improved, with the views and opinions of staff now being considered.

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 within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service was developing a local strategy using staff engagement. Staff were encouraged to identify areas of improvement within their own service and we saw evidence of these documents being completed. There was a target date for completion of the hospital strategy of August 2021. Change in practice and improvement was supported and promoted by leaders who took responsibility to explore options to increase the quality of patient care.

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.

There were listening events where staff asked questions and gave feedback. There had also been opportunities for staff to give feedback anonymously. The hospital had Freedom to Speak Up Guardians and staff knew how to contact them if they wanted to raise concerns.

The service promoted equality and diversity and embedded this into their values. The provider had committed to meeting racial equality standards. There was a staff led black minority ethnicity (BME) network and it hoped this would lead change and develop opportunities for ethnicity minority staff. The provider had partnered with an inclusion and diversity group to develop a diversity and inclusion programme which involved masterclasses and workshops for key colleague groups including those at executive level.

Leaders considered the wellbeing of staff and made sure they were supported. The service had implemented a wide range of wellbeing measures to support staff during the pandemic and staff valued this. There had been changes in the senior leadership team since our last inspection and staff spoke positively about this. Staff felt there had been a change in culture and felt empowered to raise concerns. Staff also told us they now felt heard, and managers respected and valued them.

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 was now a clear governance structure, supported by a range of meetings. At a senior leadership level there was now a governance lead, who had introduced effective governance processes to the hospital.

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Staff at all levels were clear about their roles and understood what they were accountable for. Twice daily safety meetings, at senior leadership level and with head of departments allowed sharing of safety information. The service used a third-party medical physics service and ensured open contact and sufficient advice was sought through routine engagement.

Managing risks, issues and performance

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

The department had several radiation protection supervisors in place. Controlled radiation area signs gave contact names and contact details for radiation protection supervisors. A Radiation Protection Supervisor is appointed for the purpose of securing compliance with the Ionising Radiations Regulations 2017 for work carried out in an area which is subject to Local Rules. There were radiation protection committee meetings and staff told us these were reported to departments head and the governance lead.

Managers and senior leaders monitored image reporting and appointment times. The service had identified the age of imaging equipment as a risk and there was an on-going replacement project to address this.

Managing information

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

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

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

Engagement

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

Leaders collaborated with partner organisations to help improve services for patients. They had a good working relationship with the local acute NHS trust.

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Leaders engaged with staff using a variety of methods, including; annual staff surveys, team meetings, electronic communication, newsletters, staff notice boards and in informal discussions. Staff felt their view and opinions were listened to.

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

Staff knew how to support patients to give feedback and raise concerns. At provider level the service had engaged with equality groups to develop gender identification forms to support LBGQT+ patients.

Learning, continuous improvement and innovation

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

The service was developing its local strategy and encouraged staff to be involved in it, this meant they were engaged and felt part of the strategy. Staff were developing a 'Strategy on a page' which linked to the core values of the provider. There were provider led service improvement plans in progress to support learning, improvement and innovation.

In clinical areas staff knowledge about quality improvement projects was still early in development. Training about quality improvement methodology was being given at Senior Management level and was planned to be cascaded down to staff groups. Quality improvement learning was also embedded into the 'Strategy on a page' work that was being done at clinical level.