Practice Plus Group Hospitals Limited

Practice Plus Group Hospital, Southampton

Inspection report

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

Ratings

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

Summary of findings

Overall summary

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

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The service did not always manage medicines well.
- There was ineffective oversight of medicines licensing.
- Medicines were not always stored correctly.
- Staff were not clear on the service values or strategy in place.

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

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Our rating of this service went down. We rated it as good because: • The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service. • Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week. • Most staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. • The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually. However: • The service did not always manage medicines well.

Summary of findings

- There was ineffective oversight of medicines licensing.
- Medicines were not always stored correctly.
- Staff were not clear on the service values or strategy in place.

Outpatients

Good 

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

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

However:

Summary of findings

- There were concerns with the management of the resuscitation trolley which contained items which were out of date.
- The service did not always control infection risk well. Staff were not seen to use hand sanitiser, entering or leaving the department. Chairs were not cleaned during the day.
- Staff were not always discreet and responsive when caring for patients. Staff did not always interact with patients and those close to them in a respectful and considerate way.

Outpatients was part of the hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.
We rated this service as good because it was safe, effective, caring, responsive, and well led.

Diagnostic imaging

Good

We did not previously rate Diagnostic Imaging. 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. Staff collected safety information and used it to improve the service.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and

Summary of findings

accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

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

Summary of findings

Contents

Summary of this inspection

Background to Practice Plus Group Hospital, Southampton

Practice Plus Hospital Group Southampton is an independent hospital in Southampton and is part of Practice Plus Group Hospitals Limited. The hospital is located within the Royal South Hants Hospital site. The hospital has one ward with 19 inpatient beds and a day case unit. Facilities include five operating theatres, pre-admission area, theatre sterile supplies unit, two endoscopy suites, one gynaecology suite, a physiotherapy gym room, diagnostic imaging and outpatient facilities.

The hospital provides surgery and outpatients services. Day case and inpatient surgery specialities included major and minor orthopaedics, ears nose and throat, and general surgery. The service provides elective day case endoscopy investigations for adult patients. The service did not have critical care facilities and did not provide services provided to persons under the age of sixteen.

We inspected the Surgery, Outpatients and Diagnostic Imaging services.

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

The registered manager for this location has been in post since February 2020.

We undertook this inspection as part of a random selection of services rated Good and Outstanding to test the reliability of our new monitoring approach.

How we carried out this inspection

We carried out this inspection using our comprehensive inspection methodology. We spoke with 31 staff members and 11 patients. We also reviewed patient records and feedback.

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

Outstanding practice

We found the following outstanding practice:

- The service had trained staff in all areas to be 'mental health first aiders', this aimed to support staff suffering from a mental health crisis and to direct to appropriate services until professional support could be given.

Areas for improvement

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

Summary of this inspection

Action the service SHOULD take to improve:

Surgery

- The service should ensure that cleaning is effective for infection prevention and control and that effective oversight of cleaning is implemented. Regulation 12(2)
- The service should ensure it has effective oversight for the licensing of controlled pharmaceuticals and that applications to renew are made in a timely manner. Regulation 17(1)
- The service should ensure records are stored securely. Regulation 17(2)
- The service should consider how it is assured staff are aware of the current strategy and values and are working to achieve it.
- The service should consider how it is assured that staff refer to current medicines reference sources.

Outpatients

- The service should ensure that any shortfalls in infection prevention and control are reviewed and action taken where needed. Regulation 12(2)
- The service should ensure the emergency trolley supplies are in-date at all times. Regulation 12(2)

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are Surgery safe?

Good

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

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. The service had a target of 90% completion, and this was 91% when we inspected.

The mandatory training was comprehensive and met the needs of patients and staff. Staff told us that they felt training supported their roles. Mandatory training requirements were based on staff roles with those staff who had front line clinical roles undertaking more advanced training in areas such as life support and manual handling.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

The training lead produced monthly reports for the managers to highlight team members that needed to update training. Departmental managers then alerted staff that they needed to update their training. In addition, staff received emails at routine intervals when mandatory training was approaching the renewal date.

Safeguarding

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

All staff received training specific for their role on how to recognise and report abuse. Staff with clinical roles undertook higher levels of adults and children safeguarding training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with their local authority to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us how they would escalate safeguarding concerns. We heard examples of when they had done this and how they received feedback in response to reporting.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. However not all equipment and premises were visibly clean.

Staff followed infection control principles including the use of personal protective equipment (PPE). Records provided by the service showed recent hand hygiene audits had compliance of over 93%. We also saw staff in theatres and ward areas undertaking effective hand hygiene between patient contact. Staff were bare below the elbow and using PPE effectively. We saw easily accessible hand sanitisers and PPE dispensers in all theatre and ward areas.

Environmental cleaning audits were performed monthly these indicated the service performed well for cleanliness. Most ward areas were clean and had suitable furnishings which were well-maintained. However, environmental cleaning audits from the previous month had found dust in areas and highlighted this to housekeeping staff. On inspection in the inpatient ward we saw surfaces such as keyboards at nurses' stations and window ledges in patient bathrooms that were dusty. Cleaning schedules indicated routine housekeeping had been completed.

Staff used 'I am clean' stickers equipment to show equipment had been cleaned following patient contact. However, during inspection, we saw some equipment in theatre area that had stickers stating it had been cleaned but had areas of visible dust. This indicated that both clinical staff and housekeeping staff had not cleaned effectively. We also saw a communal bathroom window on the inpatient ward where a disposable male urinal bottle was being used to prop open a window.

Staff worked effectively to prevent, identify and treat surgical site infections. In theatres equipment was transported in a one way system to keep dirty items separate from clean. Staff also used colour coded trolleys to ensure clean and dirty equipment were not mixed together. Clean equipment was transported in sterile paper on a white trolley into the theatres area. After use staff rewrapped it and placed it into a grey trolley. Used equipment was logged and taken directly into the autoclave area.

The service recorded surgical site infection rates for hip and knee replacement and submitted the data to Public Health England. The service had seven readmissions following surgical site infections in the past 12 months. We saw evidence of a root cause analysis (RCA) undertaken following a readmission for SSI. The RCA identified had identified a weak causal factor and this learning was shared with staff internal to the service and at provider level.

Staff used records to identify how well the service prevented hospital acquired infections. The service had reported no incidents of hospital acquired infections in the previous 12 months.

Staff in the inpatient unit documented wound care and used sterile equipment when changing dressings. Staff recorded observations that would indicate SSIs such as elevated temperature and dizziness in patient notes. Patients were given wound care advice at discharge and advised to contact the service if they had any concerns.

The service had also maintained a Covid-19 negative environment throughout the pandemic. Patients were screened for Covid-19 before admission through Polymerase chain reaction (PCR) tests 48-72 hours before surgery. Patients who tested positive were delayed until they had completed a period of self-isolation in line with current guidance.

Good

Surgery

Environment and equipment

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

The service had suitable facilities to meet the needs of patients and enough suitable equipment to help them to safely care for patients. The design of the environment followed national guidance. Access to theatres was via a secure door opened with a security keypad..

There were five theatre suites, two of which had laminar flow. Laminar flow theatres aim to reduce the number of infective organisms in the theatre air by generating a continuous flow of bacteria free air. This helps reduce the incidence of surgical site infections. There was a recovery area with 10 bays, but staff told us that they only used 6 to avoid the area becoming too crowded.

There was a call bell at the entrance for patients, but staff told us that patients would usually wait in reception before being accompanied through the secure door.

Patients could reach call bells and staff responded quickly when called. We saw that call bells were linked to an alert screen at nursing stations. There were also lights to visually indicate where bells had been pushed. There was CCTV at the nurse's station on the surgical ward. Nursing stations had monitoring panels to indicate location when emergency alarms and call bells were pushed.

This area was used by patients and staff when moving from theatres to recovery and to take patients in for procedures. Theatres were well lit and generally tidy however, the stock cupboards in theatres had items stored on the floor; this prevented effective cleaning.

Ward areas had multiple beds, so it was not always possibly for conversations to not be overheard but staff told us they kept their voices low to avoid being overheard. Staff carried out daily safety checks of specialist equipment. Emergency equipment had records indicating it had daily checks performed for safety although in recovery one trolley had not been tested the day prior to our visit. Columns were used to display equipment expiry date, so staff knew to replace this. The drawers of the emergency trolley were sealed with numerical single use tags to prevent unauthorised removal of equipment between checks.

Staff disposed of clinical waste safely. There were designated bins for hazardous waste, and we saw these being used. Sharps bins were labelled and partially closed to avoid spillage. We saw that these disposal bins and sharps bins were not overfull.

Assessing and responding to patient risk

Staff identified and quickly acted upon patients at risk of deterioration. Staff completed and updated risk assessments for each patient however in some areas this documentation was not well completed.

There were records containing risk assessments for falls and venous thromboembolism (VTE). VTE is a condition in which a blood clot forms most often in the deep veins of the leg, groin or arm. Patients were provided with compression stockings to reduce the risk of VTE. However recent audits of VTE documentation showed paperwork was not always completed fully and compliance was between 89-94%. Evidence provided showed communication of this audit learning point to clinical staff was limited to monthly audit reports and meetings and not further escalated despite consistent issues being identified on the previous three audits.

Good

Surgery

Patients were assessed using the American Society of Anaesthesiologist (ASA) grading system for pre-operative health of surgical patients. This is a system to record the overall health status of a patient prior to surgery. The service only undertook operations on patients with an ASA grading of three or below. The service identified patients prior to booking that were lower risk and could be cared for with the facilities it provided. Patient underwent a pre-treatment assessment in the outpatient areas. An anaesthetist and/or nurse carried out the assessment depending on the patients ASA grading and level of risk.

Patients that were identified as ASA grading three were reviewed by an anaesthetist at pre assessment appointments to gauge suitability to have their procedure with the service. Patients with complex health conditions or comorbidities would be reviewed by an anaesthetist and discussed with a multi-disciplinary team. Where it could, the service worked to support these patients to undergo surgery at their site.

Staff were alerted to any specific risk issues identified at pre assessment appointments. Staff also reviewed these risk assessments for each patient on the day of surgery this was also reviewed after any incident. Staff used the national early warning system (NEWS2) to identify deteriorating patients and escalate concerns. Patients with high NEWS2 scores were referred to the resident medical officer (RMO), anaesthetists or consultants. Audit records showed NEWS2 scores were calculated correctly and the most recent audit showed 98% compliance.

Theatre staff had a daily morning safety meeting, which ensured all staff had up to date information about issues with scheduling or cancellations that might affect the operating lists on the day.

There was emergency equipment in case of a burn, eye contamination and first aid boxes were available for staff in the day case and the inpatient ward.

The service had processes to keep people safe and used the World Health Organisation (WHO) safety checklist for surgery. The WHO checklist is a nationally recognised system of checks designed to prevent avoidable harm and mistakes during surgical procedures. The service used digital WHO Safer Surgery checklists in the main theatres, but a paper version was used in the Outpatients department. We reviewed electronic records for patients in surgery and saw that these checklists had been completed correctly.

If staff had concerns with a patient, they requested an urgent review by the Resident Medical Officer (RMO). There was a service level agreement with a local trust for the transfer of care of critically ill patients. We saw evidence that showed that this was used 16 times in the past 12 months.

All clinical staff had life support training with some staff including the RMO who was on site 24 hours having advanced life support training. The service had not had any cardiac events in the 6 months prior to inspection.

The service used a sepsis screening tool to identify and for the management of patients of suspected sepsis. Sepsis is an immune system's overreaction to an infection or injury that can result in organ failure and death. Sepsis awareness was being raised through learning sessions and the service had recently appointed a lead nurse for this area.

Following discharge patients could contact a helpline if they had concerns, this helpline was detailed on all discharge paperwork. We saw evidence that patients used this service and that conversations were documented electronically within patient notes.

Good

Surgery

Staffing

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

The service had enough qualified and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift. Staff told us managers aimed to publish rotas one month in advance.

The senior management team supported clinical services managers (CSMs) for theatres and day case unit and inpatient ward. There were CSMs for endoscopy, theatres, and ward services which included oral surgery.

The ward manager adjusted staffing levels according to the needs of patients and were able to obtain agency or bank staff with 24 hours' notice. We saw there were notice boards updated daily with staff numbers. The inpatient ward completed a safety census after each shift to review the staffing levels.

Vacancy levels and agency usage were discussed weekly with CSMs by the head of nursing and clinical services.

CSMs reported on their staffing levels monthly, this included annual leave, agency usage, sick leave, vacancies, compassionate leave and any other absences. Both the head of nursing and clinical services and the hospital director reviewed this information. Staffing shortages were reported as incidents and reported to the department manager and head of nursing, but this had not needed to be done in the 6 months prior to inspection.

Vacancy rates and retention was discussed at monthly business reviews with the hospital senior management team and the senior leadership team for Practice Plus Group. Some staff we spoke with told us that they felt there 'weren't enough staff' and they were concerned about this. Managers also told us this was one of their biggest concerns.

The service undertook safer staffing reviews every six months. The services vacancy rate at the time of inspection was 10%. The service vacancy rates had increased from 5% in the six months prior to inspection. A recruitment drive to improve this had started and a recruitment event was planned for November 2021.

The service frequently used bank and agency nurses to maintain safe staffing levels. Managers made sure all bank and agency staff had a full induction and understood the service. We saw documents that were used to induct agency staff and ensure they were familiar with all aspects of the service, prior to starting a post.

Medical staffing

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

The service had enough medical staff to keep patients safe. Patients were admitted to the service under the care of a named consultant with the relevant experience in that area of medicine. The consultant anaesthetists led the service for patient care and safety and the consultant surgeons delivered the surgical service at the hospital. The service employed medical staff on a substantive basis. The medical director reviewed and managed medical staff.

The service had a resident medical officer (RMO) who was available 24 hours a day. RMOs perform a unique role, requiring them to be on site at their contracted hospital at all times during a shift and they are often the only doctor on-site outside office hours.

The RMO was trained in advanced life support and held a bleep for immediate response, for example, in the case of cardiac arrest. The RMO told us they could also contact consultants on evenings and weekends if they had concerns about a patient's health.

Records

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

Patient notes were comprehensive, and all staff could access them easily. The service used paper and electronic patient records.

Staff told us a recent change in the tracking system created some delays as notes were assigned multiple record numbers for single physical sets of notes. This sometimes led to confusion and delays when trying to locate them, but information could be accessed electronically in the event of being unable to locate paper notes prior to attendance.

Electronic patient records were stored in a secure system that required individual log in. We also saw screensavers and prompts reminding staff of the need to lock unattended computers to restrict access. However, paper notes were not always stored securely. During our inspection, in theatres, and inpatient ward we saw the lockable notes trolleys were not always locked when they should be to restrict access.

Medicines

The service used systems and processes to safely prescribe, administer, record medicines. However, it was not always stored correctly, and staff used reference sources that were not the most current editions.

Staff reviewed patient's medicines regularly and provided specific advice to patients about their medicines. Staff followed national guidance to check patients had the correct medicines. We saw prescribing documents were stored securely.

Staff undertook audits to monitor compliance at four monthly intervals. There was no clear evidence of how non-compliance from these audits were escalated or if frequency was adjusted in response to this. Audits of medicines omissions showed compliance at 100%, inpatient medicines charts were 94% compliant. Staff reported medicines incidents and we saw that 15 had been reported in the previous 12 months this showed the service were reporting medicine incidents.

The service had systems to ensure staff knew about safety alerts and incidents. Staff followed systems and processes when safely prescribing, administering, recording, however when storing medicines this was not always followed. Some medicines were stored securely and within their recommended temperatures. However, we saw that intravenous fluid storage was not temperature monitored, this was not in line with guidance. This was raised with staff on the day who took steps to place monitoring equipment in this area. We also found a box of medicine that had not been labelled with an expiry date once opened, when we raised this issue the items were disposed of.

Pharmacy staff were observed to refer to out of date paper reference sources of some materials. Following the inspection, the service advised us that staff had access to online versions of reference sources.

Staff in pharmacy were also not aware of a list of critical medicines, this list would advise them of medications that should be stopped pre and post operatively also those that should not be missed during a patients' stay. Following the inspection the provider provided a critical medicines list that could be used by nursing staff.

Good

Surgery

However, during inspection we saw that the Home Office controlled drugs license had expired and has been applied for since inspection. The most recent audit of controlled drug compliance showed compliance was 93%.

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. There was a reporting system in place and staff had training to use it. Staff raised concerns and reported incidents and near misses in line with provider policy. The policy included definitions of incidents, their level of harm and how incidents should be reported, investigated and actions to take. Managers also supported staff with incident reporting.

Senior leaders debriefed and supported staff after any serious incident. Staff met to discuss the feedback and look at improvements to patient care. Incidents were investigated thoroughly and patients and their families were involved in these investigations.

There were changes made as the result of incidents and staff received feedback from investigation of incidents, both internal and external to the service. There was evidence of incident investigations with clear learning points and outcomes. For example, following a falls incident changes were made to all bathrooms reminding patients to alert staff if they felt faint. It was also recognised that the type of falls risk assessments had not been adapted to consider the change in surgical procedures the service was undertaking in response to the pandemic, this documentation was reviewed, and changes made.

The service had no never events, senior leaders shared learning with staff of never events that happened at other locations under the provider. Never Events are serious incidents that are entirely preventable because guidance or safety recommendations should provide barriers to them occurring. The Practice Plus Group Hospitals Limited governance lead reviewed never events and serious incidents and these were disseminated to locations with learning points.

In the event of a cardiac arrest, members of the resuscitation team would complete a resuscitation incident form, this was returned to the resuscitation lead who would also create an incident report. Relevant senior leaders would review this report. Cardiac events would also be discussed in the monthly anaesthetic group meeting and clinical governance meeting. The resuscitation incident form would also be forwarded to the Practice Plus Group Resuscitation Committee for review and dissemination of learning points.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff we spoke with were able to explain duty of candour and their responsibilities to meet the regulation. Incident investigation we reviewed showed that duty of candour was discharged appropriately.

Are Surgery effective?

Good

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

Good

Surgery

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies and guidelines were developed in line with the Royal College of Surgeons, Royal College of Anaesthetists, and National Institute for Health and Care Excellence (NICE) guidelines.

Staff told us policies were available through the service providers intranet site and showed us how to access them. We saw that all surgical policies we reviewed were in date and included appropriate references to relevant national guidance. Throughout the inspection we found staff in surgery followed national guidance and adhered to corporate policies. However, in pharmacy staff used some paper reference sources were out of date and not the most current copy.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Patients that were subject to the Mental Health Act were highlighted to staff in advance of attendance. Staff understood how the Mental Health Act applied to their own role and undertook mandatory training in this area.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. The service provided a wide menu that catered for a range of diets and religious beliefs including kosher, halal, and gluten free. In addition to this an allergen menu showed patients what items were free from common dietary allergens. The service feedback from patients regarding the food was continually positive.

Staff accurately completed patients' fluid and nutrition charts. Patients following 'nil by mouth' guidance for surgery were given information regarding this in advance. Staff checked with patients on arrival to ensure these instructions had been fully understood. Patients were given staggered attendance times to avoid waiting too long and being left nil by mouth for long periods. Staff told us that patients with diabetes were always put first on the list for surgery to avoid prolonged fasting before surgery.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients said they received pain relief soon after requesting it.

Following discharge patients could contact a helpline if they felt discomfort or pain, we saw evidence of patients using this service and staff acting on the information given appropriately.

Good

Surgery

Staff prescribed, administered and recorded pain relief accurately. Nurses administered post-operative pain medication following guidance from consultants. Pain management was part of the patient discharge process. Pharmacy and nursing staff spoke with patients about their pain medicines and gave clear instructions on its use at home.

Patient outcomes

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

The service submitted outcome data to the Private Healthcare Information Network (PHIN). Outcomes for patients were positive, consistent and met expectations, such as national standards.

The service was registered with and submitted information to the National Joint Register. The National Joint Registry (NJR) collects information in England and Wales on joint replacement operations and to monitor the performance of implants, hospitals and surgeons.

The endoscopy service was accredited by the Joint Advisory Group on GI Endoscopy (JAG). The service had recently undergone this process and staff were proud of this achievement.

Managers and staff carried out a programme of audits to check improvement over time. We were shown audit schedules that detailed routine audits that were undertaken over a 12 month period.

Audits undertaken included the World Health Organisation (WHO) surgical safety checklist, infection prevention and NEWS documentation. Observational audits were also undertaken to monitor Local Safety Standards for Invasive Procedures (LocSSIPs), these standards cover all invasive procedures including those performed outside of the operating department. Evidence provided following inspection indicated full compliance with LocSSIPs.

Managers used information from the audits to highlight areas for improvement. Where audits had highlighted areas for improvement this was highlighted to managers and staff through emails and meetings.

Competent staff

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

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

Professional registrations for staff such as registered nurses and allied health professionals were managed at provider level. This included revalidation dates. Managers told us how the staff training system could be used to upload continual professional development (CPD) evidence to registration bodies such as the Royal College of Nursing (RCN) and General Medical Council (GMC). Staff register with the GMC were given dedicated time to complete continuous professional development.

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

Good

Surgery

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff told us they had yearly appraisals and were able to discuss objectives and learning needs. At the time of inspection 100% of doctors had received an appraisal; in theatres, day case and inpatient unit this was 98%. The internal target for appraisal completion was set at 90%.

Staff had the opportunity to discuss training needs with their line manager between appraisals and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role.

If staff felt they would benefit from additional learning training leads identified internal training courses for them to attend. If there was not an internal training course available staff could apply to departmental managers for funding to cover the cost of learning, we heard how all applications were considered on the merit of benefit to the service.

Managers identified poor staff performance promptly and supported staff to improve. There was a policy to manage staff performance if this fell below the expected standard. We heard how these policies gave managers a great deal of flexibility to consider each case on an individual basis and all aspects discussed that may affect their work performance. Staff were supported to improve in the first instance however, managers were able to give examples of when poor performance had led to staff leaving 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.

Nursing and medical staff spoke positively about their working relationships and referred to being 'one big team'. Staff felt there were no barriers between professionals. Nurses told us they were able to contact medical staff easily. Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The ward had a daily round including at weekends, which consisted of an anaesthetist, physiotherapist, pharmacist and nurse. Staff told us these were useful as all inpatients were reviewed, medication and plans for discharge medications were discussed and any issues were identified. Patients were reviewed by consultant surgeons depending on the care pathway.

Shift changes and handovers included all necessary key information to keep patients safe. Staff shared key information to keep patients safe when handing over their care to others. There were also boards displaying key information in the nurse's station, these boards did not contain patient names to maintain confidentiality.

Seven-day services

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

All surgical patients followed the elective pathway and admissions were booked in advance. Diagnostic services were available out of hours.

The service did not provide emergency care. Resident medical officers (RMO) provided 24 hours seven days a week service on a week on / week off basis. RMOs told us they could contact surgeons by phone out of hours and on weekends.

The pharmacy service was available during the working day six days a week. Outside of these hours the RMO and nursing staff dispensed medications which had already been prescribed, with access to an on-call pharmacist as needed.

The service had a post-operative medical helpline, available 24 hours a day for post-operative patients for six weeks after most operations and 12 months post major orthopaedic surgery.

Good

Surgery

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards. During inspection we saw notice boards displaying information about healthy choices and lifestyle changes.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. During pre-assessment health style factors such as diet and smoking were documented, patients were signposted to NHS services to support them with health improvement.

Information was supplied to patients following surgery about gentle exercise that could improve recovery. This information was tailored to the surgical site and we saw leaflets for procedures such as mastectomy, breast lump removal, knee and hip surgery.

The service also provided physiotherapy to patients on an individual basis to support recovery. We heard how patients receiving physiotherapy were given an 'open invitation' of ongoing support following surgery and the service did not limit the length of time for follow up care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff 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. All clinical staff had training in the consent process as part of their annual mandatory training and we saw that 98% of staff had completed this.

Staff told us they gained consent from patients for their care and treatment in line with legislation and guidance. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. The service followed their corporate 'Deprivation of Liberty Safeguards Policy', 'Consent to Investigation of Treatment' Policy. Staff showed knowledge of these policies and explained how they used them. However, staff told us it was rare for any patient to be subject to any deprivation of liberty safeguards due to the preadmission risk assessment processes.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Staff told us how they discussed treatment decisions with families and persons supporting the patient to ensure a full picture of the persons wishes was obtained and considered within the consent process.

Staff clearly recorded consent in the patients' records. We reviewed patient notes and saw that consent forms had been completed in full; a copy of their signed consent forms was also supplied to the patient.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke with understood mental capacity and its considerations when gaining consent.

Good

Surgery

Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Training on this subject was mandatory and renewed annually via electronic training portals. We saw evidence that 98% of staff had completed this training.

Are Surgery caring?

Good

Our rating of caring went down. 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 took pride in providing good care and treating patients as individuals.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We saw examples of thank you cards displayed throughout the wards with comments thanking the staff for their care and support during treatment. Managers also shared thank you messages and compliments given to staff from patients in monthly bulletins.

Patients said staff treated them well and with kindness. Feedback from people who used the service and those who are close to them was continually positive about the way staff treated people. They felt cared for and feedback was positive in nature. Friends and family (FFT) surveys for September 2021 showed that 100% of patients surveyed would recommend the service. The FFT is a feedback survey that supports the principle that people who use healthcare services should have the opportunity to provide feedback on their experience.

Staff followed policy to keep patient care and treatment confidential. Staff drew curtains around beds before undertaking physical or intimate care and examinations. Staff ensured people's privacy and dignity needs were understood and respected.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. All clinical staff were responsible for ensuring the privacy and dignity of individual patients was maintained, however there were limited quiet areas within the ward areas for staff to discuss confidential matters with patients. Patients we spoke with told us that they could overhear some conversations between staff and patients in their bed bay.

Staff within theatres were respectful of patient's privacy and dignity and made sure patients were covered with gowns or blankets when being transported or escorted to other areas within the hospital. We did however see an example of patients choosing to not take advantage of this and it was not clear how staff could balance this choice with the wishes of other patients in close proximity.

Patients gave positive feedback about the service. Patient feedback form the 12 months prior to inspection said that over 98% of patients stated they experienced good service on the inpatient wards.

Good

Surgery

Emotional support

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

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients who were anxious about their procedures were supported by staff. Staff told us how they treated patients with care, and they were at the 'heart of what we do'. Patients felt they were listened to by staff and that they were given support.

At the point of admission, patients were asked about their religion and made aware a room on the ward could be made available as a quiet room or for prayer. There was also a non-denominational prayer room within the building that the service was based in.

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, involved families in conversations about treatment options by providing information for patients to take away and discuss with their families prior to surgery. Staff booking pre-operative assessments also provided written information in advance of appointments on request.

We saw staff speaking with patients, families and carers in a way they could understand. Patients told us they felt staff involved in their care and that staff listened to them.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. All patients had the opportunity to provide feedback on their care.

Staff supported patients to make informed decisions about their care. Staff told us that at pre assessment appointments discussions took place about the potential risk and complications of surgery, as well as the benefits and alternative treatment available.

Are Surgery responsive?

Good

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

Service delivery to meet the needs of local people

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

Facilities and premises were appropriate for the services being delivered. All patient attendances were planned in advance. The service could be accessed by public transport and there were adequate parking facilities and disabled parking spaces.

Good

Surgery

The service did not take emergency patients as the patients in their care were undergoing planned or elective treatment, if a patient required emergency treatment following discharge they would be admitted to their local NHS trust through the emergency care pathway. The service had service level agreements in place with the local NHS trust for transferring patients who were critically ill.

Managers planned and organised services, so they met the needs of the local population. The centre had service level agreements (SLAs) with the local NHS trust to support waiting lists and relieve the burden on the NHS from the pandemic.

During the pandemic the service had actively supported the NHS by ceasing all elective work and providing services at their site for NHS patients from two hospital trusts. The service ensured ten theatre sessions a week were available to be used by the local NHS trust to assist with their surgical waiting list. In surgery the service supported multiple pathways including cancer patients, and formed new working relationships with departments to support trauma patients. This enabled the trust to continue to deliver vital services to patients whose care may have otherwise been delayed. This also relieved pressure on the staff and capacity of these trusts during a period of unprecedented demand.

The service had contractual arrangement with clinical commissioning groups for completion of NHS work and were given referral to treatment time key performance indicators. Access was available to the NHS trust waiting lists and administrative staff were able to use these to identify patients suitable to have procedures with the service and contacted them directly. The service then transferred patients to be seen their own consultants. This reduced burden on the NHS and led to faster access for patients. Twice weekly calls were held with senior and operational leaders of the local NHS trust to support these activities.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences.

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

Patients living with dementia were identified at the pre-admission appointment and all staff were made aware of the patient's specific needs. Staff supported patients living with dementia and learning disabilities by using 'This is me' documents using information families and their carers. These documents provided staff with a better understanding of what was important to the patient.

Staff we spoke with were able to give examples of responding to patients with additional needs, they also told us how they would liaise with family members to establish individual needs. We saw feedback from a patient with additional needs who felt staff "could not have done any more to support and care for them in the way they needed". The patient felt the experience had really helped alleviate anxiety around health procedures.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service has a standard operating policy for meeting accessible standards which informed staff on how to document and highlight patient needs. There was a hearing loop in at reception to support patients with hearing impairment. Staff could also order leaflets in a wide range of languages and formats including 'easy read'. Easy read is an accessible format of providing information designed for people with a learning disability. There was an accessible standard information policy to respond to the need for information to be presented in a way that was understood by everyone.

Patients with hearing or sight impairments were flagged during pre-operative assessment and staff ensured patients could access information according to their needs. Staff provided leaflets in 'larger print'.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or British sign language interpreters. Patients could access translation services for communicating in alternate languages and this included Portuguese, French, Albanian, and Polish. Any communication needs were highlighted at pre-admission, this gave staff time to plan for additional requirements or book a translator. There was also written information in languages other than English.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients had increased but this was reflective of a national picture in response to the pandemic.

Between June-July 2021 the number of patients awaiting treatment had been reduced by 626 patients. The service had 6940 patients who had been referred and were awaiting treatment. The number of patients waiting over 52 weeks for treatment had been reduced from 1300 in March 2021 to 360 at the time of the inspection. Waiting lists were discussed with commissioners at monthly meetings and this information was presented at senior leadership governance meetings.

All patients on the waiting list had been categorised according to The Royal College of Surgeons prioritisation criteria, allowing for clinical management and to give clinical oversight of the waiting list. The service had also undertaken a harm review and had written to all patients ascertain if their wellbeing had deteriorated. This also helped support prioritisation by establishing clinical need, as well as length of wait.

There were three patient bookings hubs with designated patient pathways. Administrative staff told us this meant staff could become more familiar with the information they needed to identify suitable patients from waiting lists.

When patients arrived on the day of surgery for admission, the reception booked them in, and admission staff were notified of their arrival. They were then escorted by a member of staff to the admission bays. Managers and staff worked to make sure patients did not stay longer than they needed to. Data submitted to PHIN showed inpatient stays following procedures were in line with private healthcare service average of 2 days.

Patients that did not attend were telephoned by the bookings team on the same day to establish the reasoning behind this. This was followed up with a letter if contact could not be made. Staff recorded missed appointments on the booking system. This information could then be used by managers to monitor non-attendance rates.

When patients cancelled at short notice due to illness, bookings teams took steps to bring other patient surgeries forward. This was not always achievable as this gave only a short time period to contact patients and for them to undergo Polymerase chain reaction (PCR) test, therefore cancellations with less than 72 hours' notice could not always be utilised for others.

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

The service used a theatre management programme that monitored theatre utilisation. Managers told us this helped to plan surgical bookings more efficiently and schedulers could manage their workload better. Theatre staff also spoke positively about this system and the benefits it provided.

Good

Surgery

The provider had 'one stop' cataract clinics, this service reduced the number of attendances as diagnostic services and surgery were performed on the same day. Patients were provided with detailed information in advance of this process, so they were prepared. Consent for this process was gained on the day considering the previous information supplied.

Staff planned patients' discharge carefully. Homecare package requests were made at the initial assessment appointment, in readiness for the planned surgery taking place. On discharge each patient's GP was sent a letter through the post detailing the treatment provided.

Patients who required emergency surgeries, particularly at night, weekends and bank holidays were transferred under a service level agreement to a local NHS trust. Managers monitored patient transfers, these were reported as incidents and investigated to identify potential learning outcomes. We reviewed evidence of patient transfers that indicated all patient transfers had been as the result of a patient requiring critical medical care.

Learning from complaints and concerns

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

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

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. There was a dedicated member of staff that acknowledged and dealt with complaints.

The service had received 24 complaints in the six months prior to inspection, of these 100% had been acknowledged within 3 working days. Staff contacted the patients via telephone in the first instance for all complaints to ensure the full detail of the complaint was captured. Of the 24 complaints 15 were classified as relating to all aspects of clinical treatment. Other complaints received related to communication, appointment delays and staff attitude.

No complaints in the 12 months before inspection had been escalated to the next stage of the complaints process or had been referred to the ombudsman or the Independent Healthcare Sector Complaints Adjudication Service (ISCAS). Managers shared feedback from complaints with staff.

Are Surgery well-led?

Good

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

Good

Surgery

Leadership

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

The hospital's senior management team consisted of a hospital director, a medical director, an operations manager, and a head of nursing and clinical services. The governance manager for the service also formed part of the this team and was also the lead infection prevention and control nurse. The managers were collectively known as the Senior Management Team (SMT).

Staff told us that leaders encouraged them to ask questions, managers had developed a monthly session where staff could raise concerns or queries. Staff we spoke with said that the leadership team were supportive and open. Meetings were recorded to ensure staff could catch up on anything missed

Staff knew who managers were, and we saw there were noticeboards with photos and names of the SMT in the reception area. Staff surveys indicated they felt the SMT were less visible. Managers told us how they recognised that COVID-19 guidance and the aim to reduce footfall in the hospital, had reduced their visibility and previous lines of communication with staff such as walkarounds. They had resumed walkarounds and also planned to continue the monthly Q&A sessions as a permanent feature.

Practice Plus Group Hospitals Limited had developed a series of 12 month programmes to support staff with leadership and management skills. There were bespoke programmes were:

- New leaders
- Senior leaders
- Clinical staff moving into leadership positions

The Chrysalis programme supported clinical staff to develop and learn leaderships skills. The programme aimed to focused on bridging the gap between managerial skills and managing clinical teams. We spoke with staff who were part of the Chrysalis programme and they were positive about its influence on their leadership skills.

We saw minutes from weekly staff meeting in surgery and they showed open dialogue and discussion between staff and managers. Managers supported staff to attend team meetings provided access to the minutes when they could not attend.

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 understood and knew how to apply them and monitor progress. However staff were not always clear on the service values or strategy.

The service had recently undergone a corporate rebranding to separate its residential and healthcare businesses. Managers told us the service had identified a strategic vision of delivering 'Access to excellence'. We reviewed this strategy after our inspection and saw that it included a key performance indicators and goals for the future

Good

Surgery

The service was in the early stages of developing a continuous improvement transformation plan. The impact of the pandemic had increased workload in all surgical areas, this meant work on developing this strategy 'from the ground up' had been paused. The service had recently undertaken a planning exercise to resume this work, managers felt this would have a positive influence and form the basis of a new transformation strategy. The service also had a strategy tracker which it used to monitor progress.

There were a set of corporate values in place and these were:

- We treat patients and each other as we would like to be treated
- We act with integrity
- We embrace diversity
- We strive to do things better together

However, during inspection, we saw little evidence of these values on display. Staff we spoke with were also not aware of corporate values. This was also evidenced in the staff survey where the following statements had shown downward trend and staff saw these statements less favourably from previous years:

- The Exec Team have set clear goals and objectives for Practice Plus Group
- Senior management encourage us to discuss our organisational goals
- Senior management convey a clear strategy for our organisation

Culture

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

Staff told us they were able to speak up about concerns and were supported by managers to do this. Senior leaders took time to host open question and answer sessions where staff could ask the hospital director questions and get a response.

The service had a newsletter that featured a message from members of senior management, and updates of events in the service. The service had taken measures to help staff feel valued, this included plaudits in newsletters and on notice boards. There were monthly staff awards based on nominations from staff. Staff were also awarded for long service with vouchers.

We saw evidence of senior managers supporting staff with their wellbeing and providing resources to improve wellbeing. There was also an employee assistance programme that could be accessed for advice and support.

The service had trained seven staff who worked in all areas to be 'mental health first aiders. This aimed to support provided to a staff experiencing a mental health problem until professional help is received or until the crisis is resolved. Staff were encouraged to speak with 'first aiders' and advised this was confidential. The aim of this was to:

- Preserve life where a person could be a danger to themselves or others
- Alleviate suffering by providing immediate comfort and support
- Prevent the condition from developing into a more serious problem
- Promote recovery of good mental health by signposting and obtaining professional support

Staff took part in an annual survey called 'Over to you'. Results from the survey in 2020 showed that 67% of staff agreed with the statement 'Practice Plus Group cares about my health, safety and wellbeing', this was an improvement on the previous year.

We saw posters in waiting areas explaining to patients how they could also raise concerns. When patients raised concerns, they were contacted so this could be investigated. Senior leaders investigated complaints and oversaw the process with staff whose roles were dedicated to this task. The registered manager had final sign off for all complaint responses.

Leaders told us the service was committed to supporting staff and it regarded any form of bullying or harassment as unacceptable behaviour. Incidents of harassment or bullying would be investigated and where appropriate result in disciplinary procedures. The service had policies in place to support this and these included a grievance policy, a bullying, harassment and victimisation policy, and a disciplinary policy.

Staff completed an equality and diversity module within mandatory training. The service had an equality and diversity policy as well as an equality, diversity and inclusion steering group at provider level. Workforce Race Equality Standard (WRES) data was reported at provider level but this had been paused nationally due to the pandemic.

Governance

Leaders operated governance processes, throughout the service and with partner organisations. However, these were not effective in some areas. 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. Staff had opportunities to engage in audit.

The senior management team met weekly to discuss finance, scheduling contract reviews and business reviews. These meetings fed into a fortnightly core governance meeting that informed the all staff monthly meeting. The governance manager produced a monthly report for the core governance meeting gave an overview of information such as incidents, audit outcomes and shared learning.

There were monthly clinical governance and assurance afternoons and all staff could attend this subject to their individual availability. Ward staff told us they could not attend if they were working clinically, previously the service had closed to facilitate this.

Meetings had a rolling agenda which comprised of items such as policies, safety alerts, audit outcomes and incidents. These meetings were also attended, where possible, by an external guest speaker who gave a presentation on a relevant topic such as learning disability awareness.

Information from these meetings was also escalated to senior leaders at corporate level. This was also reported at a board level with Practice Plus Group Hospitals Limited senior management. Learning was then shared in newsletters and in departmental meetings. We saw minutes of meetings where audit outcomes had been discussed and areas for improvement discussed with staff. Managers shared information from the audits with staff.

Surgery managers held a weekly staff meeting update staff and disseminate information from meetings they had attended. These meetings in turn fed into the monthly team leaders meeting.

There was a two way flow of information between senior leaders and clinical staff. The service had a clear reporting structure that staff understood. We were also shown an organogram which visually demonstrated to staff which meetings had oversight for various monitoring processes. For example, infection prevention, medicines management, and health and safety were reported in the quality governance and assurance meeting. This enabled staff to see clearly what meetings would cover items and gave staff responsible for providing these updates clearly defined time frames to manage workload.

Good

Surgery

Evidence from some audits showed communication of learning points solely via monthly audit reports and meetings with no escalation when areas of non-compliance were consistent. This was evidenced in VTE and environmental cleaning audits where issues had been identified on the previous audits with no clear action or oversight from month to month when there were themes in non-compliance.

The senior management team did not however have timely oversight of medicines licensing. During inspection it was noted that the Home Office controlled drugs licence on display in reception had expired. Following the inspection the service provided assurance that this licence had now been renewed. However, evidence produced indicated that an application had not been made prior to its expiration. The Home Office website advises to allow 16 weeks for processing of an application. The governance manager monthly reports for the previous 4 months did not evidence discussion of this license renewal. Furthermore, the quarterly update given by the medicine's management forum for the period of June - August 2021 did not contain any information relating to this.

Management of risk, issues and performance

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

We saw evidence of incident reporting and associated action plans. Leaders told us that there were plans to update the incident reporting system as this would help support staff when reporting.

The service had a risk register in place, these was discussed weekly in senior management meetings. There were nine risks currently registered; one rated as high risk, four as moderate and four rated as low risk. All risks had mitigating actions documented. The service listed its top three risks as:

- Business disruption due to sterilisation equipment failure
- Prolonged absence impacting patient care
- Staff that are medically able refusing COVID-19 vaccination

Senior leaders knew these risks when we spoke to them, and when staff were asked about their concerns these matched documented risks.

Managers told us staffing was a concern for them. There were plans to hold a recruitment event in November to promote the service and encourage job applications. Human resources and departmental managers jointly managed all vacancies. A weekly agency spreadsheet was submitted to the human resources director, the resourcing manager, the hospital director, the operations manager, head of nursing and clinical services and the finance manager to show current usage and forecasting. The levels were by set by CSMs (clinical service managers) and safety thresholds determined any need for escalation. A representative from the recruitment team also attended the service to discuss vacancies and applicants with the department leads.

Information Management

The service collected reliable data and analysed it. Data or notifications were consistently submitted to external organisations as required. However, the information systems were not always integrated and secure.

Clinical audits were comprehensive and provided reliable data. There were opportunities for clinical staff and there was independent checking of audit data which was challenged appropriately. This information was reviewed by the

governance lead who fed this back to senior leaders and the clinical commissioning group. Information collected was used to measure improvement and where appropriate action plans were developed. For example when incident reporting highlighted a low trend of patient falls, a multidisciplinary team to review causation factors and repeat audit was introduced.

Information systems were not always integrated and secure. Paper records were not locked away when not in use however, electronic records required staff to use their individual passcodes to access them.

The service submitted data to the Private Healthcare Information Network (PHIN). PHIN is intended to improve the availability of information to patients for private healthcare services, making the information comparable with that which is already available for the NHS. There was a quarterly board level exercise in place for the service to benchmark its services against others.

Engagement

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

Patient feedback was collected and reviewed to identify strengths and areas of improvement. Feedback from this was consistently positive in nature.

Senior leaders held 'Q&A" sessions for staff to engage with them. The service undertook staff surveys and responded to suggestions from these. Staff spoke positively about monthly governance meetings. All staff told us the leadership team kept them informed about progress and changes. Staff felt they were able to approach managers with ideas or and we heard from staff that had done this.

There was an active patient forum group who reviewed information and made improvement suggestions. This had been suspended during the pandemic but had recently resumed. The forum had vacancies and leaders told us they would be looking to appoint members from a diverse range of backgrounds to generate discussion.

The service had undertaken significant amounts of work for the local NHS trust during the pandemic and told us this had strengthened their working relationship. The senior management team worked closely with their Clinical Commissioning Groups (CCG), GPs and acute trusts to plan services for the local population. This included weekly contact with the CCGs to direct more patients to the service. They were also raising awareness with local GPs to increase referrals. Senior leaders were working with the CCG to support the ongoing recovery of services from the impact of COVID-19.

The service had collaborated with partner organisations and trained staff to work as vaccinators. They had also supported services by providing staff to work in multiple NHS services and to ensure the continuation of these services during the demands of the COVID-19 pandemic.

Learning, continuous improvement and innovation

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

Staff had rapidly adapted to a change in surgical procedures and patient workload in light of the pandemic. It was recognised by leaders that the efforts of staff had ensured that they could support the local NHS trust at a capacity which relieved NHS workload and waiting lists.

Good

Surgery

The service had appointed a Sepsis lead nurse who had shared learning with the clinical commissioning group.

The service had recently launched a quality improvement (QI) academy, this was available to all staff. The QI academy goal was to teach improvement methods to staff who wished to be involved in a project.

Staff from the service had set up a quality improvement group in December 2020. Staff had spoken to patients and identified areas they felt there could be improvement. However, the pandemic had inhibited efforts to continue with this work and it had been paused.

Staff had undertaken accredited training to be PCR Swab takers.

The service was in the process of establishing a new service pathway for patients with Age Related Macular Degeneration as an addition to its existing Ophthalmology services. The service was planned to offer static and mobile services. This was hoped to reduce traveling for patients and limit this to no more than 15 miles from their home address.

Good

Outpatients

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

Are Outpatients safe?

Good

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

Mandatory training

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

Staff received and kept up to date with their mandatory training. Mandatory training for staff covered topics including manual handling, fire safety and information governance. Other training that staff required was made available to them for example, new policies and ways of working.

The mandatory training was comprehensive and met the needs of patients and staff. For example, all staff completed training about information governance and infection prevention measures.

Managers monitored mandatory training and alerted staff when they needed to update their training. However, staff said reminders were not consistent.

Safeguarding

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

All staff received training specific for their role on how to recognise and report abuse. They knew how to identify adults and young people at risk of, or suffering, significant harm and worked with other agencies to protect them. The service did not treat children but did treat young adults (16-18), the majority of young adults being treated were for oral surgery. Staff gave examples of when they would make a safeguarding referral.

Staff gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act (2010). Staff protected patients through observation, listening to their patients and their friends and family and taking appropriate action, when necessary.

Staff followed safe procedures for children and young people visiting the department.

Good

Outpatients

Cleanliness, infection control and hygiene

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

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. The department was bright and visibly clean with chairs spaced to offer social distancing. The department had dispensers of clean gloves, aprons and masks. Antibacterial hand gel dispensers were available, and signs prompted staff and visitors to clean their hands regularly.

The service generally performed well for cleanliness. The department shared its cleaning record with patients on a notice board. The display on the board at the time of inspection was dated August 2021, when the department scored four stars (the maximum was five).

This reflects what was seen on the board on the day.

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

During the morning of the inspection, no staff were seen to use the hand gel dispensers when entering or leaving the department and only one patient (out of 30) used them. The department had a high footfall, with staff coming and going. We asked the manager what they expected of staff regarding the use of hand gel. They described the expected behaviours of using it when entering and leaving the department, and that some staff chose to have small bottles in their pockets to use. Staff told us they would usually practice hand hygiene in front of patients. In an outpatient setting, this is usually done in the consulting room, in front of the patient, therefore this would not have been observed in the reception area.

Environment and equipment

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

Staff carried out daily safety checks of specialist equipment. The outpatient department was cleaned in the morning before clinics started and, in the evening, to minimise disruption to patients and staff during the day when clinics were being held. All medical equipment was the responsibility of the nursing and healthcare assistants to clean after each use, and everything else was the responsibility of the housekeeping team.

The physiotherapy room was clean and equipment was stored appropriately.

The service had enough suitable equipment to help them to safely care for patients. We reviewed three consulting rooms in the outpatient's department and found no concerns. In all these rooms "I am clean" stickers were used to indicate equipment that was ready to use, and hand sinks were available for hand washing. Personal protective equipment such as gloves and aprons were available, and consumable items were checked and found to be within their expiry dates.

Staff disposed of clinical waste safely. Substances subject to the control of substances hazardous to health (COSSH) regulations 2002 were stored securely all waste was segregated. All the sharps bins inspected were properly assembled, labelled and signed and dated in line with best practice and filled below the line indicated on the bin. All storerooms were tidy. Hazardous substances were locked in a COSHH (Control of Substances Hazardous to Health) Cupboard and handled in line with the control of substances hazardous to health regulations 2002.

Good

Outpatients

Resuscitation equipment was located in the outpatients corridor. This was shared with the diagnostic imaging department. The resuscitation trolley contained supplies which were out of date. We raised this with the service on the day of our visit and were told they were aware of the expired items, but that there had been difficulty obtaining replacements from suppliers. These items were replaced by staff before the inspection team left the site.

Staff carried out daily resuscitation equipment checks. We reviewed the records for resuscitation equipment checks from August to October 2021, and these were mostly completed accordingly.

Assessing and responding to patient risk

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

Staff responded promptly to any sudden deterioration in a patient's health. All staff at the hospital including outpatient staff received training to enable them to deal with life support scenarios. Senior staff nurses completed immediate life support training and basic life support training; all other staff completed basic life support training.

Staffing

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

Clinics were arranged based on patient demand, determined by the volume of new referrals and follow up appointments required. These were determined by the clinic and theatre scheduler, who created the clinic rota and assigned consultant surgeons and anaesthetists as required. The outpatient manager staffed the clinics accordingly. No bank or agency staff were used. When there was sickness, staff levels were lower leading to staff covering double the clinics. However, staff spoke about a good team spirit. Sickness rates were comparable to similar services during the Covid pandemic.

There was a health care support worker for each consultant who had clinics. The nurses ran clinics for preadmission assessments prior to surgery and Covid tests. The nurses, consultants and health care staff were supported by administration staff on the reception desk.

The department manager managed the rotas and planned the off-duty six to eight weeks in advance. The notice board clearly indicated where staff were working and which consultant they were assisting.

The manager was aiming to have all staff trained to work in all clinics, extending their roles in some cases. It was felt a variety of work will help with staff wellbeing.

For further information regarding medical staffing see information under this sub-heading in the surgery report.

Records

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

Patient notes were comprehensive, and all staff could access them easily. Staff kept detailed records of patients' care and treatment. Records were clear, and available to staff providing care. Records were either stored within the secure medical records department, an office or in a locked record trolley during clinics.

Good

Outpatients

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

Records were stored securely. We saw some staff transferring paper notes by hand. They were not left on desks and were handed to administration staff to give to the consultant. The notes were removed from the consulting rooms as soon as the consultant had completed their appointments.

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. There were no controlled drugs or chemotherapy stored or administered in the department. A limited basic stock of pre-labelled broad-spectrum antibiotics were kept in case the consultant needed to prescribe a course to a patient in clinic. Prescription pads were logged and stored under lock and key in a designated cupboard for this sole purpose and were checked daily. The individual blank prescriptions were signed out by two witnesses and the prescribing doctor and the recipient was documented for each prescription. There was a pharmacy on site where prescriptions could be collected.

Emergency cardiac arrest and anaphylaxis medicines were kept on the resuscitation trolley and were checked daily. Anaphylaxis is a life-threatening allergic reaction that requires immediate treatment.

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

Incidents

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

Staff knew what incidents to report and how to report them. Staff said that there was a 'revolving door' for reporting incidents or problems so that issues could be put right. For example, the management of clinics when there was staff sickness.

There were no never events reported relating to the outpatient department. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them.

Managers shared learning with their staff about never events that happened elsewhere. Staff met every Monday to share any events that had occurred and share good and poor practice.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff were familiar with the duty of candour regulations and were able to explain what this meant in practice. They identified the need to be honest about any mistakes made, offer an apology and provide support to the affected patient. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Good

Outpatients

Are Outpatients effective?

Inspected but not rated

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies were developed in conjunction with national guidance and best practice evidenced from professional bodies, such as the Royal College of Nursing, National Institute for Health and Care Excellence (NICE). All the guidelines we reviewed were easily accessible on the services intranet and were up to date.

The service also had a local audit programme that included a chaperone audit, waiting times and hand hygiene audits. Staff who competed the audit had not recorded any concerns with staff and patients not using the hand gel.

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, for example dental and clinics which reviewed wound dressings.

Patients received pain relief soon after requesting it.

Staff prescribed, administered, and recorded pain relief accurately.

Patient outcomes

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

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

Managers shared and made sure staff understood information from the audits. The information was shared in staff meetings.

Doctors shared their opinions with us regarding the treatment of wrist ganglion cysts, (a ganglion cyst is a fluid-filled swelling that usually develops near a joint or tendon.) The treatment policy meant patients had to attend twice for treatment.

Test results were viewed on the electronic systems by staff.

For further information on this please see this section under the surgery report.

Competent staff

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

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. The recruitment checked that staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All staff received a disclosure and barring (DBS) check when they joined the department.

Managers gave all new staff a full induction tailored to their role before they started work. New staff were given an induction pack. The pack included, departmental structure, opening times, parking arrangements, wellbeing and uniform.

Each department had a mental health support champion, information on how to access this was on a poster in staff room. Staff said the management team did a 'walk around' but not on a regular basis. The last staff survey said managers were accessible but not visible.

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisals and continuous professional development (CPD) were tracked on an online system and we saw examples of staff clinical and business objectives, CPD and any development they would like to undertake over the coming year.

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

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

Multidisciplinary working

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

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

Nursing staff confirmed they had good working relationships with consultants and could easily ask for help. They also had good relationships with the imaging team and physiotherapy team. They had quick access to diagnostic test results, which were saved on the electronic system and accessible to all staff in the outpatient's department.

As part of the multidisciplinary approach to benefit patient care, nurses were receiving procedure training for Carpel Tunnel pre Covid but that had not resumed.

Good

Outpatients

Patients could see all the health professionals involved in their care at one appointment. For example, a patient who attended the ear, nose and throat clinic, had a hearing test before seeing their consultant.

Seven-day services

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

The outpatients service was open from 8am – 6pm.

Health promotion

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

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

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were aware of their responsibilities under the Mental Capacity Act (2005). They were able to talk about the deprivation of liberty safeguards and how this would impact a patient on the unit. Staff told us they had not come across a patient who lacked capacity. Staff could demonstrate an understanding of the hospital's policy but told us they had not had to put this into practice.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff were clear about their responsibilities in relation to gaining consent from people, including those people who lacked capacity, to consent to their care and treatment. Our review of eight medical records showed well documented consent forms were completed. Staff could tell us how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff had access to best practice guidance and local mental capacity policies in the department.

Staff made sure patients consented to treatment based on all the information available and clearly recorded consent in the patients' records. Where a patient was aged 16-18 staff followed the service's guidance and policies.

Staff could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards.

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

Are Outpatients caring?

Good

Outpatients

Good

Our rating of caring went down. 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 said staff treated them well and with kindness. Patient, family and friends' feedback for August 2021 was seen on the noticeboard and the comments were positive about staff and care. For example, "Thank you. You have been amazing." Clinic rooms had 'busy/free' signs on the doors, and we observed staff knocking and waiting before entering clinic rooms. Patients said they felt their privacy was always respected during their appointment.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Although due to the Covid pandemic patients were encouraged to see the doctor or nurse on their own, where it was needed, staff offered for a carer or family member to accompany the patient.

However, staff were not always discreet and responsive when caring for patients. Staff did not always interact with patients and those close to them in a respectful and considerate way. We saw most staff treat patients and visitors with warmth and care. Most staff interactions with patients; were courteous, professional and demonstrated compassion to all patients. We saw staff of all levels coming to collect their patients, they spoke in a respectful manner told them who they were, their role and what they were doing, for example 'I am Fred and I will be carrying out the first part of your appointment today.' However, one member of staff called a patient's name, said 'hello' and walked off; they did not introduce themselves. On a second occasion the same member of staff came into the reception area said, 'hello, how are you?' then proceeded back into the clinical area, again with no introduction.

Staff also did not always follow the provider's policy to keep patient care and treatment confidential. Of the seven staff we saw coming out to collect their patient, one member of staff started discussing personal information with two patients before they had left the reception area this could have been overheard by other patients waiting.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it to help minimise any distress or anxiety. There was no information in the reception/waiting area advising patients they could request a chaperone. However, staff told us once patients moved from the waiting area to a seat in front of the consultation room, there was information on the door of each consultation room regarding access to a chaperone. A healthcare assistant always attended outpatient clinics.

Staff told us upsetting or unexpected news was delivered sensitively and in appropriate private surroundings.

Reception staff routinely spoke with patients in the reception area to help with any concerns they had and liaising with other departments to meet patient's needs.

Good

Outpatients

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. Patients said they were given explanations about their treatment. They said staff explained procedures and obtained their consent before any treatment. Patients told us the consultants were thorough, they spent time explaining procedures to them and they felt comfortable and reassured. They felt they were given clear and adequate information.

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

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Are Outpatients responsive?

Good

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

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the changing needs of the local population. Staff said patients were usually seen promptly following their referral. Patients were given the next available appointment with their chosen consultant. Patients confirmed they had not waited long for their appointment.

We observed a relaxed atmosphere in the outpatient area. The waiting areas were not overcrowded, and clinics were running on time. Clinics ran in the outpatient's department between 8am – 6pm. Patients told us they were able to get appointment times that suited their needs.

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. Consultants also made phone calls to patients to discuss treatment and care, although this usually worked well the number of patients then having to attend the hospital was increasing.

Facilities and premises were appropriate for the services being delivered.

Managers monitored and took action to minimise missed appointments. Senior staff discussed non-attendance with the receptionist and clinic leaders. Managers ensured that patients who did not attend appointments were contacted.

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.

Good

Outpatients

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. Although all information leaflets in the department were in English, staff told us they could be printed in other languages or larger print. Although the hospital could provide translation services if needed, there were no information posters advising patients what was available for them. However, on initial referral to outpatients, staff would ensure that communication was possible with the patient at their appointment, which included translation service if needed.

There was disabled access, toilet facilities and guidance available in the car park to assist patients with parking.

Access and flow

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

Reception staff welcomed visitors to the department and redirected them if they were lost.

Patients were referred to the outpatient's department by their GPs, or they could self-refer. Patients could book an appointment by submitting a form online or by making a telephone call. Patients were offered the most convenient appointment with the appropriate consultant.

All seven patients we spoke with said it was easy to make an appointment and were seen quite quickly on their arrival at the department. Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

Managers worked to keep the number of cancelled appointments to a minimum. If patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Staff said the number of people attending the clinic was reduced due to infection control cleaning. Extra clinics had been arranged to keep waiting times down. Telephone and video consultations were available for appropriate patients at any stage of their pathway, pre or post operatively.

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.

Feedback leaflets and comment cards were available in the department to encourage patients to give their feedback and report concerns. However, they were in English only. Feedback from patient experience questionnaires between January and August 2021 achieved 99%. The national target was 75% feedback. Staff told us that the feedback leaflets and comment cards could be made available for patients in alternative languages and formats.

Staff said they tried to resolve complaints informally. However, if patients wanted to raise it further, they escalated complaints to the manager. We saw evidence that learnings from complaints were used to improve the service.

Good

Outpatients

Examples of issues were displayed on the noticeboard under 'you said, 'we did'. For example, 'An increase in same day diagnostic and imaging appointments would reduce the number of return visits and improve the patient pathway'. Response – 'Most staff have access to imaging on the same day as the initial consult. We are working towards improving availability further'. 'There are difficulties trying to reach the department by phone,' response – 'A restructure of the admin team has taken place to improve efficiency and responsiveness'.

For our detailed findings on complaints please see the Responsive section in the surgery report.

Are Outpatients well-led?

Good

Our rating of well-led went down. 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.

Staff told us they understood the departmental structure and knew who their line manager was. They reported feeling able to discuss issues with their line manager and felt they could contribute to the running of the department.

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 anaesthetics team were updating a 'pre-op exclusion criteria', to enable outpatient nurses to take more responsibility so patients do not have to have multiple assessments. Theatre audits for surgical assessments indicated there were no cancellations due to nurse's pre assessment.

Staff felt that although phone calls could be useful best practice was to see patients face to face as a visual assessment could be useful. Some patients we spoke with said they preferred face to face appointments whilst others who struggled to get to the hospital liked the phone call.

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

Culture

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

Good

Outpatients

Staff said there was a positive culture in the department. They told us they had not experienced any discrimination and they had been supported to maintain a work /life balance. The hospital had an anti-bullying policy in place and staff said they worked in a healthy environment. Staff said it was a nice place to work and there was a friendly atmosphere in the department.

Staff said they were motivated to go the extra mile to make sure patients receive the best care and are safe. Staff confirmed the department was open and transparent and they could raise any concerns with senior staff. Staff said, "Our ethos is – we are a team, pull together, we are going to make it work."

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

Governance

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

Medical staff attended clinical governance and orthopaedic meetings monthly to monitor the service.

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

Management of risk, issues and performance

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

The outpatient's department had a quarterly health and safety monitoring action plan.

The service operated an employed consultant model. A complete and robust process of interview, pre-employment checks occur when consultants are appointed. Staff said they received regular support and were made aware promptly of concerns as well as being given praise.

Information Management

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

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

Engagement

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

Good

Outpatients

Results of the patient survey were on display in public areas in the department. There was limited specific areas about engagement in relation to the outpatient service.

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

Learning, continuous improvement and innovation

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

Senior staff told us, one health care support worker was being supported through an apprenticeship to become a nurse. The deputy theatre manager worked alongside two more health care support workers in the outpatient department to provide extended competences to enable them to assist with minor procedures in the department. A health care support worker had also become an assistant practitioner with an extended role working in Ophthalmology to develop a new 'Age Related Macular Degeneration Service'.

In addition, regular teaching was provided by the consultant anaesthetists to the outpatient team.

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

Good

Diagnostic imaging

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

Are Diagnostic imaging safe?

Good

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. We rated it as good.

Mandatory training

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

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory and statutory training was provided by a combination of eLearning and face-to-face training sessions. The mandatory training was comprehensive and met the needs of patients and staff. Staff told us that they felt training supported their roles. Mandatory training requirements were based on staff roles with those staff who had front line clinical roles undertaking more advanced training in areas such as life support and manual handling.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

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

At the time of our inspection, 94% of diagnostic imaging staff had completed their mandatory training against a target of 90%. Staff who were non-compliant had recently started working for the service. Additionally, diagnostic and imaging staff completed targeted training, such as IR(ME)R training, Radiation Protection, and management & leaderships courses.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Safeguarding children and vulnerable adults formed part of the mandatory training programme. Staff we spoke with told us they had received safeguarding training. Records showed that all staff had completed adult safeguarding training and all staff were also compliant with

children safeguarding training at levels two and three. All clinical staff completed level 3 training for both children and adults safeguarding. This was in line with the recommendations from the Intercollegiate Document adult safeguarding: roles and competencies for health care staff (August 2018) and the Intercollegiate Document safeguarding children and young people: roles and competencies for healthcare staff (January 2019).

The service had a safeguarding lead with level 4 adult and children safeguarding training. All staff we spoke with knew who the safeguarding lead was and how to contact them.

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

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

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

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

Cleanliness, infection control and hygiene

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

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

The service generally performed well for cleanliness. The service undertook a monthly infection control environmental audit to check compliance with the infection control and prevention policy. The audit results from August to October 2021 demonstrated compliance above the 95% target for all months.

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

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

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

Good

Diagnostic imaging

We reviewed hand hygiene audit results from August, September and October 2021, and compliance was consistently at 100%. The audit results were shared at the team meetings. We observed staff using hand gels and sanitising before and after seeing each patient.

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

Environment and equipment

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

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

The service had suitable facilities to meet the needs of patients' families. The imaging department was located on the second floor, with a lift for access. The reception area provided ample waiting space and toilet facilities.

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

There was enough space for staff to move around the x-ray equipment and for x-rays to be carried out safely. We saw warning signs and lights in use on the day of our inspection, all areas were monitored and had oversight from the reception staff.

The x-ray room was accessed off the main reception. The room where radiation exposure took place was clearly marked with warning signs and lights.

Clear signage was in place to warn patients of areas where radiation exposure took place, therefore limiting risk of accidental exposure.

Lead screens were in place to protect staff from radiation. These were checked on an annual basis by the service's medical physics expert.

Lead aprons were available for use if required and were subject to regular integrity checks by the service's medical physics expert.

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

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

Servicing and maintenance of premises and equipment was carried out using a planned preventative maintenance programme.

Good

Diagnostic imaging

During our inspection we checked the service dates for equipment, including x-ray equipment. All the equipment we checked was within the service date. All x-ray equipment was also tested monthly on a planned schedule to avoid cancellations or delays.

Resuscitation equipment for diagnostic imaging department was located in the outpatient's corridor. This equipment was shared with the outpatient's department.

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

Assessing and responding to patient risk

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

Staff completed MRI safety questionnaires for any appropriate patient, using a recognised tool. For example, the service used a patient safety questionnaire. Risks were managed and updated in line with any change in the patient's condition. Patient referrals were checked at the point of referral for any potential safety alerts that required further investigation through the dedicated patient management system, which also linked with the incident reporting system .

Processes were in place to ensure the correct patient received the correct x-ray at the right time. The service had a Society of Radiographers (SoR) 'Pause and Check' poster within the unit. These are used as a reminder for staff to carry out checks on patient identity and referral before performing a procedure.

We saw staff checking three-points ID to correctly identify the patient. Completing 'Pause and Check' provides assurance that the radiographer had the correct procedure, the correct patient and correct part of the body was undergoing the x-ray.

Staff responded promptly to any sudden deterioration in a patient's health. There were processes for staff with regards to people using the service who became unexpectedly unwell or if an unexpected result was found during the x-ray. If a patient required urgent treatment staff told us they would call 999 for an emergency transfer to the local hospital. However, we did not see a procedure for admissions of deteriorating patients to the NHS.

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

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

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

Each imaging area contained an emergency alarm cord in the event of emergency or patient collapse.

Child-bearing status was routinely checked prior to any imaging taking place. Additionally, there was signage to protect members of staff who may be pregnant. Staff confirmed the patients' name, date of birth and address, confirmation of

child-bearing status, and also ensured the patient had read information on procedure to be carried out. We saw these checks being carried out on the day of our inspection. However, the questionnaire was not gender neutral. This made it less inclusive and accessible to trans and non-binary patients. Whilst this is not a regulatory requirement, it is recommended according to current national guidance. The provider updated the forms after our inspection.

Staffing

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

The service had enough staff to keep patients safe. Staffing levels were planned and reviewed in advance to ensure that an adequate number of suitably trained staff were available for each clinic.

The manager could adjust staffing levels daily according to the needs of patients. A dedicated bank staff rota had been developed to support staff. Rates of agency and bank staff usage were at 215.00 hours for agency radiographers,19.00 hours for bank radiographers, 47.50 hours for agency sonographers and 28.50 hours for bank sonographers. This means that the department used bank and agency staff only when strictly needed, which allows for consistency and continuity of care. Additionally, agency and bank staff received a full induction, which complies with national and internal guidance.

The service had a low vacancy rate. Four senior radiographers and two sonographers, alongside two student radiographers were employed at the time of our inspection. Staff told us there was a good ongoing recruitment drive, at the time of our inspection there were two vacancies for Senior Radiographers. According to the safer staffing report for September 2021, an open doors recruitment event was planned for November 2021 to attract more staff.

The service had reported no sickness for clinical staff from August to October 2021.

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

Medical staffing

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

The service had enough medical staff to keep patients safe. There was a resident medical officer (RMO), with the relevant experience on site 24 hours, seven days a week with on-call access to patients' consultants during evening and weekends. Consultants were easy to contact, responsive to requests and engaged with the RMO. The RMO was trained in advanced life support and held a bleep for immediate response, for example, in the case of cardiac arrest.

Records

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

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

Good

Diagnostic imaging

Records were stored securely. Patients' personal data and information were kept secure. Only authorised staff had access to patients' personal information. Staff training on information governance was part of the mandatory training.

Prior to completing an x-ray, staff confirmed that the patient had consented. Once the x-ray was completed, staff submitted the images to a radiologist for reporting.

We reviewed five patient records during our inspection and saw records were mostly accurate, complete, legible and up-to-date. However, one patient record did not include the answer to the pregnancy questionnaire, although the information was included in the notes. We raised this with the service on the day and they rectified the situation.

The service provided electronic access to diagnostic results and could share information electronically if referring a patient to a hospital.

The service used a communication system (PACS) to view images, for radiologists to report and transfer to the referring clinician. It was secure, and password protected. Each member of staff had their own password to access the information system.

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

Medicines

The service followed systems and processes to safely record medicines and store consumables.

There were no patient medicines, including controlled drugs or medications stored or administered in the department. Staff followed process when recording patients known prescribed medicines to ensure known risks were documented.

The department submitted weekly orders of consumables and there were no contrast agents used within the department. Staff stored consumables in line with process to ensure safety and to restrict access.

Emergency cardiac arrest and anaphylaxis medicines were kept on the resuscitation trolley in the outpatient's department. Anaphylaxis is a life-threatening allergic reaction that requires immediate treatment

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

Incidents

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

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

Good

Diagnostic imaging

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

There were no never events reported for the service from August 2020 to October 2021. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

In the last 12 months, there were no serious incidents reported for the service. Serious incidents are events in health care where there is potential for learning or require using additional resources to ensure a comprehensive response.

There was a process for reporting and recording incidents that occurred within the department. The provider told us that incidents are investigated at service level in line with their policy. The service reported two incidents in the previous 12 months. Both these incidents were unintended exposure of radiation. This means that the radiographer carried out an x-ray of an incorrect area. Incident reports contained the required details according to national standards and internal policies. Neither incident met the threshold to be reported to the CQC.

We saw evidence of feedback and learning for the two incidents we reviewed.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff we spoke with could tell us their understanding of the requirements of the duty of candour regulation. For example, we saw evidence that staff apologised to patients following the above incidents.

Staff received feedback from investigation of incidents, both internal and external to the service. Learning from incidents was shared with staff at daily safety huddle, team meetings, and by email.

Staff used a specific form to record and report radiation doses greater than the intended dose. The service had a named radiation protection advisor (RPA) who would review any incidents relating to radiation.

Are Diagnostic imaging effective?

Inspected but not rated

In accordance with our current methodology we do not rate effective in Diagnostic imaging.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983. Managers checked to make sure staff followed guidance but it was not clear what action was taken when audits identified areas for improvement.

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

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.

Good

Diagnostic imaging

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

Patients care and treatment was delivered, and clinical outcomes monitored in accordance with guidance from the National Institute for Health and Care Excellence (NICE). NICE guidance was followed for diagnostic imaging pathways as part of specific clinical conditions.

The service had local rules based on national guidelines. We also reviewed the clinical governance report from July to October 2021. We found the local rules provided clear guidance on areas relating to hazards and safety and the responsibilities of staff to ensure work was carried out in accordance with the local rules. The X-ray unit had its own local rules with a suitable review date. All local rules were all in date.

There were also general audits for infection and prevention control and patient experience. The service also monitored waiting times, image quality assurance and quality of referral form to ensure these met national standards.

The service had an annual radiation protection audit of the clinical environment and this included a review of exposure settings.

Local radiation audits were completed monthly to assess clinical practice in accordance with local and national guidance. We saw evidence of these audits and that they looked at a range of patient examinations to monitor quality by considering factors such as marker placement, record keeping and pregnancy status.

Nutrition and hydration

Patients had access to drinks to meet their needs.

Staff made sure patients had access to water. 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 monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and supported patients to use their own pain relief medication as needed.

The department did not provide analgesics to patients, but staff monitored patients regularly to see if they were in 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. We saw staff asking patients if they were comfortable during their procedure.

Patient outcomes

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

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

Good

Diagnostic imaging

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

Competent staff

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

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

The department included four senior radiographers, two sonographers, two student radiographers, and a radiation protection supervisor who covered at national level. Further, agency and bank radiographers were employed based on demands.

The department had a mental health support champion, information on how to access this was on posters found in the staff room and the reception area.

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

Managers supported staff to develop through yearly, constructive appraisals of their work. Data provided by the service showed that 100% of staff had completed an appraisal in the last 12 months prior to the inspection. This was in line with the internal target.

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

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

Multidisciplinary working

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

Staff told us that they worked closely with other providers who referred patients to their service to provide a seamless treatment pathway for patients.

Good

Diagnostic imaging

Staff told us there was good communication between services and there were opportunities for them to contact other providers for advice, support and clarification. There was a pathway for advanced practice, through which the reporting radiographer shared learning and knowledge with another location.

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

Seven-day services

Diagnostic Imaging services were not available seven days a week, but arrangements were made to support timely patient care.

The diagnostic imaging department was open from 8am to 6pm Monday to Friday and provided cover for theatres on Saturdays.

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

Health promotion

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

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

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

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

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

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

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

Are Diagnostic imaging caring?

Good

Diagnostic imaging

Good

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. We rated it as good.

Compassionate care

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

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

Patients said staff treated them well and with kindness. All four patients we spoke with described staff as caring and kind. Staff ensured that patients' privacy and dignity was maintained during their time in the diagnostic centre and during x-rays. Staff ensured patients were covered as much as possible during procedures to preserve their modesty and dignity.

Staff told us negative comments were discussed for opportunities to drive improvement in the service which included changes to premises, staff training or patient information.

Emotional support

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

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

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

Understanding and involvement of patients and those close to them

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

We saw staff making patients as comfortable as possible. They ensured the patient was in control throughout the x-ray. We saw patients being advised should they wish to stop their examination, staff then assisted them and discussed choices for further imaging or different techniques and coping mechanisms to complete the procedures.

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

Good

Diagnostic imaging

We observed that staff answered patients' questions appropriately, and in a way they could understand. Staff explained to patients how and when the results would be sent to the referring clinician. Staff gave patients information leaflets on what an x-ray would involve and what was expected of them before the procedure and answered any questions. They also provided information to patients on self-care following an x-ray.

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

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

Patients gave positive feedback about the service. We reviewed the detailed patient survey results for October 2021, and overall patient satisfaction scores from May to September 2021. Feedback patients gave was very positive, such as "quickly seen and very descriptive of the operation", "quick and efficient, time taken to explain everything very clearly and answer my questions", "excellent service, as always", "excellent service and helpful staff". The patient satisfaction score from May to September 2021 was 98%.

Are Diagnostic imaging responsive?

Good

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Managers planned and organised services so they met the changing needs of the local population. Staff said patients were usually seen promptly following their referral. Patients were given the next available appointment with their chosen consultant. Patients confirmed they had not waited long for their appointment. Senior staff discussed non-attendance with the receptionist and clinic leaders. Managers ensured that patients who did not attend appointments were contacted.

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

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

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

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

Good

Diagnostic imaging

Meeting people's individual needs

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

The service and all areas within the service were accessible to wheelchair users. This included level access from the car park set down area and automatic entry doors at the main entry as well as entrances to the diagnostic imaging department.

Staff had completed their mandatory training in mental health, and they told us they had support to assist any patients with mental health struggles. Additionally, staff gave us examples of how any such cases flagged up on the electronic system and reasonable adjustments could be made well in advance, including allowing patients to be accompanied by a carer or a family member.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff were able to give examples of when these documents had been used to support patients. The department had help from the inpatient team dementia champion. Additionally, all senior radiographers had experience and training in supporting patients with dementia. The electronic patient management system flagged these cases to staff, and carers were allowed to accompany these patients as needed.

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

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

An interpreting service was available for patients whose first language was not English. Most staff we spoke to showed knowledge and awareness of the service and knew who to contact if required. However, we did not see any posters containing information about the translation and interpreting services available to staff.

The service had arrangements to meet the needs of those with sensory impairment. Hearing loops were available in the service, which helped those who used hearing aids to access services. Staff told us they allowed more time for appointments depending on the patients' specific needs on the day. Service users we spoke to confirmed staff were very patient and accommodating and waited to ensure they felt informed and comfortable regarding the procedure.

Staff gave us examples of supporting patients with protected characteristics. Protected characteristics according to the Equality Act 2010 are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

However, the questionnaires and pre-assessment forms were not gender neutral. This made them less inclusive and accessible to trans and non-binary patients. Whilst this is not a regulatory requirement, it is recommended according to national guidance. The provider provided told us they had updated these forms since inspection.

Access and flow

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

Good

Diagnostic imaging

Managers monitored waiting times and made sure patients could access services when needed. People could access the service when they needed it. Patients were offered a choice of appointment and staff told us that there was no issue with providing appointments in a timely way. The turnover times from April to September 2021 (appointments completed) were within the established KPIs (key performance indicators) at 99.6%.

The average turnover time for imaging across all modalities from April to September 2021 was 25.68 hours, or approximately one day. This was in line with the service targets and KPIs.

The service did not have any patients waiting for diagnostic imaging appointment for more than 6 weeks. Ultrasound requests would be booked in with the preferred sonographers and could at times be done on the same day or within a week. This complied with internal KPIs.

Managers worked to keep the number of cancelled appointments to a minimum. If patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. Main reasons for cancellations were DNAs (did not attend), which we saw managers and staff discussed in meetings and addressed with short-term and long-term action plans.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. All the patients we spoke with knew how to make a complaint or raise concerns. Details on how to give feedback was displayed on notice boards throughout the clinic. Managers told us that patient feedback was reviewed monthly and shared with at staff meetings. Staff contacted any dissatisfied patients if they left their details, and resolved the issues raised.

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

The service reported they had no complaints in the previous six months. We reviewed minutes of patient forums from where complaints were discussed and learning was shared. We also saw that the complaints had been investigated and responded to in line with the policy. We saw evidence of the changes implemented as a result of complaints and feedback – such as changes to the booking process for switching of patients between consultants, which allowed the receiving consultant to review the case notes before accepting the patient or making reception staff aware to ensure the volume of their conversations was lower and that service users in the waiting area did not overhear sensitive information.

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

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning from complaints was communicated to staff through staff meetings and emails.

Are Diagnostic imaging well-led?

Good

Diagnostic imaging

Good

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. 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 hospital had a clear management structure in place with defined lines of responsibility and accountability.

The hospital was led by a senior management team consisting of a hospital director, a unit medical director, the head of nursing and clinical services. There was an imaging manager for the department and a radiation protection supervisor who covered at national level.

All staff we spoke with told us they had a good relationship with their managers, and they felt supported in their roles and able to access additional training and courses for professional development. Staff gave us examples of courses and training they had requested and discussed with their leaders and told us they felt supported to achieve career progression.

Vision and Strategy

At the time of inspection there was no strategy in place for the service. This was currently in the development stage to turn it into action. Managers told us the vision and strategy would be focused on sustainability of services and aligned to local plans within the wider health economy.

The service's vision and strategy documents mainly focused on "treating patients and each other as we would like to be treated", "acting with integrity", "embracing diversity" and "striving to do things better together". The strategy also contained a plan to tackle a potential resurge of the COVID-19 pandemic.

The service is committed to adopting QSI (quality standard for imaging) in order to be assured that the entire evidence healthcare regulators require will be easily available within their quality management system and a quality culture is embedded across the service. The service had discussed and approved the budgeting for obtaining this accreditation. The (QSI) has been developed by The Royal College of Radiologists and the Society of Radiographers to set out the criteria that defines a quality imaging service. The QSI enables services to develop quality improvement building on their existing evidence base.

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

Culture

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

Good

Diagnostic imaging

Staff were consistently positive when describing the culture within the service. They felt supported by all leaders and colleagues within the service. Staff felt respected and valued. All staff we spoke with were happy in their role and stated the service was a good place to work.

During our inspection we saw that staff interacted and engaged with each other in a polite, positive and supportive manner. We also witnessed staff deliver care to patients and saw that they were focused on individual patient needs, allowed enough time for the patients to express their needs and ensured information to patients regarding the procedures was clear and in plain English.

The service generally promoted equality and diversity and it was part of mandatory training. Managers and staff promoted inclusive and non-discriminatory practices. The provider had reported on WRES (Workforce Race Equality Standard) data as required. However, the internal policies did not include an associated EIA (equality impact assessment). Equality impact assessments are a tool to help organisations ensure that their policies, practices and decisions are fair, meet the needs of their staff and patients and that they are not discriminating against any protected group.

Staff completed an equality and diversity module within mandatory training. The service had an equality and diversity policy as well as an equality, diversity and inclusion steering group at provider level. The service promoted equality and diversity in daily work and provided opportunities for career development.

A whistleblowing policy, the duty of candour policy and appointment of freedom to speak up guardians all supported staff to be open and honest. Staff we spoke with told us they felt confident and safe to raise concerns with no fear of repercussions or discrimination.

There was generally good communication in the service from both local managers and at corporate level. However, the staff survey results for 2020 indicated that staff felt remuneration and visibility from senior management were not satisfactory. Additionally, staff survey results showed that communication around strategy and vision was lacking at the Southampton site.

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.

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

The service operated a clinical governance and assurance framework which aimed to assure the quality of services provided. At board level quality monitoring was through the clinical governance and safety committee. The diagnostic imaging lead reported to the hospital director and was involved in these meetings and processes.

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

Good

Diagnostic imaging

The service also held annual radiation protection committee meetings, attended by their dedicated radiation protection supervisor (RPS) and the national clinical specialist for imaging.

Management of risk, issues and performance

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

Performance was monitored at local and corporate level. The service had implemented a monthly policy tracker tool, supporting staff and managers to ensure awareness of latest amendments and if any policies were due a revision.

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

Radiation protection advice (RPA) was provided by service level agreement (SLA) with a radiation protection advisor (RPA) from an external NHS trust. The RPA report from 2020 found no concerns. Additionally, there was spare equipment to use for any unexpected events. The equipment was operational and all the checks were in date.

Staff we spoke with were aware of the risk recording tool available. They were able to give us examples of using it to highlight risks. There was a risk evaluation system at national, regional and departmental level. We reviewed the risk registers and found them to be detailed, up-to date and compliant with national standards and regulations. Staff we spoke with were aware of the diagnostic imaging risk register and the hospital risk measurement system.

For our detailed findings on management of risk, please see the “Well led” section in the surgery report.

Information Management

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

The service 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.

The service collected, analysed, managed and used information well to support all its activities, using integrated and 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.

Good

Diagnostic imaging

Leaders collaborated with partner organisations to help improve services for patients. They had a good working relationship with the local acute NHS trust. Additionally, staff gave us examples of supporting the local acute NHS trust during the height of the pandemic, by carrying out various imaging procedures, as needed. We also saw feedback provided by local NHS trusts thanking the service for their valuable contribution at the height of the pandemic.

Leaders engaged with staff using a variety of methods, including; annual staff surveys, team meetings, electronic communication, newsletters, staff notice boards and informal discussions. Most staff felt their view and opinions were listened to. However, the survey did indicate that some staff at the Southampton site did not feel sufficiently involved and informed with regards to changes and new strategies.

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.

Learning, continuous improvement and innovation

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

We saw noticeboards that displayed comments from patients and staff and actions the service had taken to improve services. Additionally, the diagnostic imaging department was scheduled to undergo significant renovation and expansion from January 2022. We saw documents reflecting the action plans around this and found they were detailed and also included business continuity for various scenarios.

The diagnostic imaging department offered apprenticeships and training opportunities which helped to develop the skills and offered career progression to individuals in the team. In addition, it meant the service could grow their own talent which helped with staff retention.