

Nuffield Health

Nuffield Health Cheltenham Hospital

Inspection report

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Date of inspection visit: 26 August 2022
Date of publication: 17/01/2023

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 well-led?

Good 

Summary of findings

Overall summary

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




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

- Bank staff did not meet the provider's minimum target for completion of mandatory training.
- The fabric in some parts of the building reduced infection control compliance and presented avoidable risks.
- The persistent use of agency nurses resulted in increasing delays to discharge, although risks around these were well managed.
- While standards of care record keeping were good, there were persistent challenges around consultant willingness to comply with provider standards in outpatients.
- Information governance in diagnostic imaging was a known trend in incidents and had not yet been fully resolved.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	We rated this service as good because it was safe and well led. Please see the main summary.
Outpatients	Good 	Our rating of this service stayed the same. We rated it as good. Please see the main summary. Where arrangements were the same for surgery and outpatients, we have reported our findings in the surgery section.
Diagnostic imaging	Good 	We have not previously rated diagnostic imaging as a separate service. We rated it as good. Please see the main summary. Where arrangements were the same for surgery and diagnostic imaging, we have reported our findings in the surgery section.

Summary of findings

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Summary of this inspection

Background to Nuffield Health Cheltenham Hospital

Nuffield Hospital Cheltenham Hospital is operated by Nuffield Health and is one of the organisation's 31 hospitals nationally.

The hospital offers a wide range of clinical specialties within surgery, outpatients, and diagnostic imaging to private and NHS patients. At the time of our inspection the mix of patients was 65% private and 45% NHS.

Surgery includes a dedicated pre-assessment unit, three theatres, a six-bedded recovery area and a 32-bedded inpatient ward. Specialties include gynaecology, urology, orthopaedics, ear, nose, and throat (ENT), and hips and knees. Around 65% of all surgery takes place on a day case basis.

Outpatients operates from a dedicated area of the building with consulting rooms, a minor operations theatre, phlebotomy facilities, a physiotherapy service, and well-equipped rehabilitation gym. The physiotherapy team offer specialist sports medicine services and a dedicated pelvic floor physiotherapist offers a highly specialised menopause service. The minor operations service includes dermatology, gynaecology, and flexible cystoscopy. The hospital has an endoscopy service on site.

Diagnostic imaging services include MRI, CT, DXA, mammography, ultrasound, and X-ray. The team also offers in-theatre radiography services.

We last inspected the service in March 2016. We rated the service good overall and good in each core service key question except for safe in surgery, which we rated requires improvement. At this inspection we found the hospital team had addressed all our previous areas of concern. At our last inspection, we inspected outpatients and diagnostic imaging as a combined service. Since then our methodology has changed and we inspect outpatients and diagnostic imaging as separate core services.

A registered manager is in post and the service is registered to carry out the following regulated activities:

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

Where arrangements were the same across core services, such as mandatory training compliance, governance and senior leadership, we have reported findings in the surgery section.

We rated this service as good because it was safe and well led.

Summary of this inspection

How we carried out this inspection

We carried out an announced inspection of the service on 26 August 2022 using our focused methodology. We inspected surgery, outpatients and diagnostic imaging. The inspection team consisted of a lead inspector and a specialist advisor with support from an inspection manager. During our inspection we spoke with staff, observed care being delivered, and reviewed audits and other clinical records. After our inspection the provider sent us over 150 pieces of evidence of their practice, which we considered when coming to our ratings.

We undertook this inspection as part of a random selection of services which have had a recent Direct Monitoring Approach (DMA) assessment where no further action was needed to seek assurance about this decision and to identify learning about the DMA process.

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 maintained a strong community presence that underpinned the provider's charitable aims and goals. Staff organised a continual engagement programme that included GP educational events and medical events open to the public, tailored to local and regional health needs. The team advertised events through the hospital's social media channels and posters displayed in the building and ensured they were inclusive and equitable.
- Staff were highly responsive in implementing targeted, focused resources and signposting for patients who presented with vulnerabilities and needs not usually seen in the hospital. This included dedicated support for teenagers visiting the physiotherapy and outpatients services who had sexual health and other needs, for patients living with dementia during extreme weather events, and for those with complex communication needs.
- A dedicated specialist infection prevention nurse had significantly impacted new policy and practices in the hospital. They had worked across all departments, trained link practitioners, upskilled staff, and raised awareness of risks and best practice. The nurse had introduced a series of guidance papers tailored to specific staff and teams.

Areas for improvement

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

Action the service **SHOULD** take to improve:

- The service should prioritise the removal of carpets in clinical areas as part of refurbishment plans.
- The service should continue to work towards a standardised records process with all consultants in outpatients.
- The diagnostic imaging service should expedite work to improve information governance around scan images.
- The service should continue to improve bank staff training compliance.

The service should ensure World Health Organisation hand hygiene posters are up to date.

Our findings

Overview of ratings


Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Not inspected	Not inspected	Not inspected	Good	Good
Outpatients	Good	Not inspected	Not inspected	Not inspected	Good	Good
Diagnostic imaging	Good	Not inspected	Not inspected	Not inspected	Good	Good
Overall	Good	Not inspected	Not inspected	Not inspected	Good	Good

Good 

Surgery

Safe Good 

Well-led Good 

Is the service safe?

Good 

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

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. Between January 2022 and September 2022, the service maintained an average 95% compliance. This was better than the provider's 90% target. Bank staff had 82% training compliance and the senior team were supporting the team to improve.

Compliance figures included international nurses working towards their Nursing and Midwifery Council test of competence (OSCE). This team of nurses completed the same mandatory training as permanent nurses, which reflected good practice.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Permanent staff had good access to this training and completed it as an additional element of their overall training programme.

Department managers and the senior leadership team monitored mandatory training and alerted staff when they needed to update their training. The provider's central training and learning team monitored training needs and provided targeted support.

The provider encouraged healthcare assistants (HCAs) to complete a level three national vocational qualification (NVQ) in healthcare. At the time of our inspection, all HCAs held this qualification.

An operating department practitioner was the training lead for theatre and supported staff to stay up to date. A scrub nurse was completing a 'train the trainer' programme in manual handling and planned to deliver practical refresher training to all staff, including agency staff.

In addition to the standard mandatory training package, staff had access to additional training to support their roles and development plans. For example, porters were undertaking a vocational course in transporting and managing medical gases safely. The senior team was increasing the number of staff with antimicrobial stewardship training to better manage medicines and antibiotic practices.

Surgery

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. Nurses were trained to safeguarding adults and children level three and received additional training in caring for patients with needs relating to autism and learning disabilities. At the time of our inspection 94% of staff were up to date with training.

The matron was the safeguarding lead and held higher level training. The provider's national safeguarding lead provided additional support.

The overarching safeguarding policy and approach incorporated a range of training and initiatives. All staff completed government PREVENT training, which helped professionals to identify people at risk of extremist indoctrination. The provider had a reporting process for female genital mutilation and staff understood how to respond to claims or evidence of abuse.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. The team had enhanced this knowledge during pandemic lockdowns when they noted patients with high levels of vulnerability presented for care and treatment.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The provider had several escalation pathways and key points of contact for staff. This included the hospital safeguarding lead and the provider's national duty safeguarding lead. The hospital maintained up to date referral information for the local authority safeguarding team and gave examples of how they could contact safeguarding teams for out of area patients.

The hospital did not provide a children and young people service and surgery did not treat patients under 18 years of age. Staff followed safe procedures for children visiting the ward. All patients had private bedrooms, which enabled staff to facilitate safe visits.

The service reported two safeguarding incidents in the previous 12 months. Incident reports demonstrated staff had acted quickly, including making a referral to the modern slavery and exploitation helpline and escalating their concerns internally to secure immediate support.

Staff described clear safeguarding processes, including points of escalation tailored to each stage or department of care. Staff who worked in the hospital under practising privileges undertook safeguarding training in the use of local policies as part of their induction. This ensured all staff had a standardised approach to safeguarding procedures, which reflected good practice

Cleanliness, infection control and hygiene

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

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. The service performed well for cleanliness. Staff used a rolling programme of 14 audits to monitor standards of infection prevention and control (IPC).

Surgery

This was a comprehensive, well-structured system that included standards of practice delivered by staff and cleanliness of the environment. In the previous 12 months the service scored 87% compliance. This was an average figure that reflected high levels of compliance with hand hygiene (96%) and areas for improvement in the environment and fabric of the building (67%). Staff demonstrated consistently good hand hygiene practice during our inspection.

The provider was aware of challenges in maintaining good IPC in some areas of the building, such as carpeted areas awaiting removal. Mitigation included steam cleaning and the relocation of clinical services from carpeted areas.

Staff followed infection control principles including the use of personal protective equipment (PPE) and the aseptic non-touch technique (ANTT). We saw this in evidence during our inspection.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Clinical treatment areas, including consultation rooms, had privacy curtains labelled with the latest usable date. All the curtains we checked were within their date and staff in each department told us named staff tracked curtains to ensure compliance with provider standards. Staff cleaned the theatre between patients and additionally at the end of each list.

Staff worked effectively to prevent, identify and treat surgical site infections (SSI). In the previous 12 months the average SSI rate for all surgical specialties except abdominoplasty was 1.6%. This was an average and reflected consistently good practice. For example, there were no SSIs reported in spinal surgery.

Staff reported a 14% SSI rate in abdominoplasty and reviewed the patient cohort appropriately to identify if any of the infections could have been avoided. The clinical team concluded the infections were known risks due to the nature of the treatment and they had taken all practicable steps to avoid them. The cohort presented with known high levels of risk and surgeons incorporated this into the consent process with patients, which was evidence of good practice.

Staff reported suspected SSIs in the incident reporting system as a near miss and converted this to a confirmed incident if an infection was identified.

Staff maintained a log of post-surgical care following an SSI, which showed they implemented a comprehensive care programme that included a wound review by the resident medical officer (RMO), appropriate blood tests, and a renewed post-surgical care plan.

Staff kept up to date with IPC training. At the time of our inspection 92% were up to date with IPC overall, 97% with hand hygiene, and 84% with ANTT.

A dedicated housekeeping team worked in the hospital daily from 7am to 9pm. Out of hours staff allocated cleaning duties and accessed an on call service for urgent deep cleaning.

A dedicated specialist infection prevention nurse had significantly impacted practice, knowledge, and engagement in the hospital. They had worked across all departments in the hospital to train link practitioners, upskill staff, and raise awareness of risks and best practice. The nurse had introduced a series of guidance papers tailored to staff in different roles and departments and worked with the senior team to update and improve policies. They had recently departed the hospital and quality care partners ensured their innovative work remained in place to support staff. They achieved this by using the new policies and training guidance to benchmark standards of practice and supporting departmental link staff to work with colleagues to coach best practice.

Surgery

World Health Organisation (WHO) posters with hand hygiene guidance was posted at handwashing sinks. This had not been updated to new guidance that included the wrists. We spoke with staff about this who said they would secure more up to date posters.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. Each patient bedroom had a call bell and we observed staff ensured they were within reach of each patient as part of hourly checks.

The design of the environment did not fully follow national guidance. Not all clinical areas had dedicated handwash sinks for staff and some areas were carpeted. This was not in line with national guidance and the provider had a refurbishment plan in place to upgrade the department.

Staff carried out and documented daily safety checks of specialist equipment. The senior team used a planned preventative maintenance programme for clinical equipment to reduce the risk of failure and short-notice procedure cancellations.

The service was compliant with the Control of Substances Hazardous to Health (COSHH) Regulations. Staff stored chemicals in locked, fire-proof areas with good standards of stock documentation. Housekeeping staff we spoke with demonstrated a good understanding of the regulations and standards of practice.

The service had suitable facilities to meet the needs of patients. Theatres and ward bedrooms were spacious, well equipped, and comfortable. Two theatres had laminar flow air filtration systems, which protected patients from infection risk during longer procedures.

Resuscitation equipment was located in clinical areas. This included airway management equipment, oxygen, and automatic external defibrillators (AEDs). Staff documented daily and weekly stock checks to ensure the equipment was ready for use. Each resuscitation trolley included PPE stock and guidance that reflected Resuscitation Council UK updated guidance.

Staff managed, streamed, and disposed of clinical waste safely. Procedures were in line with national guidance and protected staff and patients from harm.

The service was compliant with Department of Health and Social Care guidance and the Health and Safety Executive Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 in relation to sharps waste. The hospital had introduced a new programme of reusable sharps safety devices that reduced waste. Staff had undergone training in safe use of the equipment.

Cleaning teams flushed taps daily to reduce the risk of Legionella, a bacterium that can grow in water outlets that are used infrequently. An external supplier tested the water supply weekly, which was compliant with national guidance.

Assessing and responding to patient risk

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

Surgery

Staff used the national early warning scores (NEWS2) tool to identify deteriorating patients and escalated them appropriately. They used the tool for all patients who received care as good risk management practice. Where a patient deteriorated, staff used the SBAR (situation, background, assessment, recommendation) process to structure appropriate assessment of their needs.

The team audited correct use of NEWS2 and in the previous 12 months the service achieved an average 77% compliance. Senior staff supported improved practice identified in audits, such as a more proactive escalation response to worsening NEWS2 scores whilst awaiting emergency teams.

Staff completed life support training to a level commensurate with their role. All staff, including non-clinical staff, completed basic life support (BLS) and at the time of our inspection 99% of clinical staff and 82% of non-clinical staff were up to date. All registered clinical staff were trained in immediate life support (ILS) and three staff were progressing to advanced life support (ALS). Of ILS-trained staff, 91% were up to date. There was always anaesthetic trained staff whenever theatres were in operation and surgeons and anaesthetists were trained to BLS, ILS, or ALS level. Resident medical officers (RMOs) held ALS and airway training and contributed to monthly life support teaching sessions.

Each clinical area had a sepsis pack for use in emergencies, which provided rapid access to essential equipment. Staff were trained to use the national 'Sepsis six' pathway and posters were displayed around the hospital.

Staff completed risk assessments for each patient at key stages of treatment, using recognised tools, and reviewed these regularly, including after any incident. The pre-assessment team carried out medical risk assessments with each patient to identify conditions or history that may present a risk of harm with the proposed care plan. In the previous 12 months, surgery teams averaged 80% compliance with risk assessment standards in monthly audits.

Staff knew about and dealt with any specific risk issues, such as for sepsis, falls, and venous thromboembolism (VTE). In the previous six months, VTE audits found 84% average compliance with expected standards. Ward staff carried out pressure ulcer and waterlow risk assessments for admitted patients. We saw staff consistently documented risk assessments and all the records we looked at were up to date.

The theatre team used the WHO surgical safety checklist to safely manage procedures. We observed good standards of communication amongst the theatre team during our inspection, with full adherence to the WHO process. Monthly audits found consistent practice, with 99% compliance in the previous 12 months.

Staff shared key information to keep patients safe when handing over their care to others and shift changes and handovers included all necessary key information to keep patients safe.

The operations manager worked with staff to implement a range of improvements in fire safety following a previous evacuation. This included improved understanding of designated roles and fuller use of all emergency exits.

In August 2022 a resuscitation officer carried out a simulated emergency medical call in the hospital. Overall staff performed well and implemented local emergency 'crash' procedures and Resuscitation Council UK protocols appropriately. The senior team worked with staff to implement areas for improvement, such as improved chest compressions during manual resuscitation.

Staff were proactive in updating care and treatment pathways to reduce risk as part of continual learning and audit feedback. For example, surgeons had updated the pre-operative anaemia optimisation pathway to promote better recovery after the treatment. This involved liaison with the patient's GP to start oral iron and a referral to a local iron clinic.

Surgery

In the previous 12 months the hospital reported a 0.2% return to theatre rate. Staff investigated instances to identify if there were themes for learning. In the same period staff carried out one emergency transfer and seven urgent transfers. The senior team reviewed each instance using a root cause analysis framework to ensure clinical practice and response in the hospital was appropriate. Each review identified good practice in response to patient needs and no thematic areas for improvement.

The pre-operative assessment team worked with patients to reduce risk factors by providing lifestyle advice around alcohol consumption, physical exercise, and smoking.

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 nursing and support staff to keep patients safe. In the previous 12 months the service maintained a nurse to patient ratio of 1:6. While this was enough to keep patients safe, there was significant pressure on the system due to the numbers of agency nurses used. Agency nurses were registered professionals but did not have the same level of knowledge of provider and hospital protocols, which placed additional pressure on permanent nurses.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants, and healthcare assistants (HCAs) needed for each shift in accordance with national guidance. The service supported student nurse practitioners in their training, which improved capacity and consistency of care.

The ward manager could adjust staffing levels daily according to the needs of patients. They used daily capacity meetings to identify potential pressures on the system and arrange additional staff. A team of bank scrub nurses from NHS services and other independent providers regularly worked in the hospital to support capacity and reliability.

Staff met each morning to identify emergency roles, including for the resuscitation team.

The service had vacancies for four full time, permanent registered nurses and reported a turnover rate of 4% and a sickness rate of 4% in the previous 12 months.

Managers made sure all bank and agency staff had a full induction. Staff spoke positively of their relationships with bank and agency colleagues and the matron was working with agencies to provide the same nurses consistently.

Four nurses and one or two HCAs provided the pre-assessment service. This included a mix of in-person and telephone clinics, based on patient risk, and a nurse coordinator.

Each department held a morning huddle in which the team reviewed patient needs in advance, checked staff wellbeing, and reviewed open incidents.

We observed good staff handovers between theatre and recovery teams, with effective communication based on patient need and risk.

Surgery

Surgeons and consultants worked under practicing privileges and most were in substantive posts in the NHS. All surgeons had a designated buddy as part of the practicing privilege agreement. They provided pre-planned care, arranged in advance with the hospital senior team, and were required to uphold the provider's standards and policies. The medical advisory committee maintained oversight of practicing privilege arrangements and reviewed standards of clinical practice, patient outcomes, and incidents.

Consultants and surgeons reviewed their own patients on the ward in line with patient need and care plans.

A resident medical officer (RMO) was based in the hospital 24/7. They provided on-demand patient reviews across all departments and joined handovers and service-level meetings with consultants and other clinical staff. RMOs were trained in airway management to support deteriorating patients.

The senior team adjusted surgical services to reflect a regional shortage of anaesthetists. Surgeons carried out procedures using local anaesthesia where this was safe and secured anaesthetist cover for procedures that were best carried out under general anaesthetic.

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 prepared health records in advance of a surgical list, so the nursing and healthcare support team was prepared for each case. Clinic lists included flags for patients with known safeguarding risks or other needs such as anxiety or dementia.

Records we looked at were comprehensive and clearly written. They included appropriate risk assessments, care and treatment notes, allergens, and referral details. Staff had signed and dated all entries, which was good practice.

The senior team audited the management of health records for detail, consistency, availability, and management in line with provider standards. In the previous 12 months staff achieved a 92% average, which was better than the provider's 90% target.

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

Records were stored securely. Staff stored paper records in locked facilities with limited access. Electronic records were encrypted, and only authorised, trained staff had access. The provider's IT team had 24/7 cover for system failures or cyberattacks.

The hospital provided care and treatment for patients through a variety of different referral routes, including self-referral. This meant consultants used a range of referral and pre-assessment documentation with differing levels of medical history. Quarterly audits highlighted that pre-assessment staff often needed to contact referring services to provide more information before patients could safely be accepted for treatment. To address this, staff had piloted different single patient record systems to standardise information the hospital received to be assured of safe care and treatment planning. The result was the establishment of a minimum level of information required for staff to plan care and assess needs, regardless of whether referrals came from NHS services or independent clinicians. This included a referral letter, GP summary, and evidence of a multidisciplinary review and meant the senior team were assured of good standards of patient care planning.

Surgery

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Consultants and surgeons prescribed medicines using the provider's standard operating procedure. An on-site medicines management lead and pharmacy team provided compliance oversight and support.

Staff completed medicines records accurately and kept them up-to-date. They documented stock checks, pharmacy returns, and medicine administration in care plans.

Medicines were stored in each clinical area for ease of access. Each theatre had its own medicines store, supplemented by medicines storage on the ward. Staff used a stock control system to ensure medicines were used or disposed of before their expiry date. They documented temperature checks of ambient and refrigerated storage to ensure medicines remained within the manufacturer's guidelines.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. The senior team had carried out work to improve discharge guidance for patients following incidents in which GPs had been unable to prescribe the recommended medicines.

Staff learned from safety alerts and incidents to improve practice. Staff reported 28 medicine incidents in the previous 12 months. None of the incidents resulted in patient harm or triggered the formal duty of candour process but staff documented open and honest discussions with patients and external healthcare providers as good practice. The senior team identified themes and adjusted policies and training to reduce future risk, which was evidence of a good learning and education programme. For example, the team implemented new discharge training for agency nurses, provided consultants with new guidance on to take away (TTO) medicine processes, and provided RMOs with training on non-steroidal anti-inflammatory drugs (NSAIDs).

Staff followed national guidance and Home Office regulations to manage Controlled Drugs (CDs) safely. Two registered nurses documented stock and storage checks of CDs twice daily and the pharmacist carried out regular spot checks on local processes.

We observed safe standards of CD management during our theatre observations, including contemporaneous documentation and tracking. Quarterly audits of CDs indicated broadly good practice, with some areas in need of improved practices, including compliance with required documentation in theatres and the maintenance of an up to date approved staff signature list. Staff had implemented improvements following the audits.

The hospital had a comprehensive antimicrobial stewardship (AMS) programme in place. The pharmacy team worked with an external consultant microbiologist to ensure post-surgical prescriptions met the provider's safety policy. AMS accountabilities were clearly assigned in an up to date policy and reflected best practice, including input from the local infection prevention and control lead and a key contact at a microbiology laboratory that led investigations. The team audited practice quarterly as a tool to highlight good practice and opportunities for improvement. In 2022, the team met the provider's 91% target in two out of three quarters and achieved 92% overall. The audit team worked with surgeons to ensure improvements were made when practice did not meet policy standards, which reflected good safety practice.

The pharmacy team audited medicines compliance quarterly. The most recent audit from September 2022 indicated 100% compliance with provider standards with room for improvement in their response to alerts from the Medicines and Healthcare products Regulatory Agency (MHRA).

Surgery

Theatre staff maintained a blood bank and we observed good processes for maintaining safe storage and use.

Quarterly audits of medical gas storage reflected consistently good practice in line with national standards.

Incidents

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

Staff knew what incidents to report and how to report them. They raised concerns and reported incidents and near misses in line with provider policy using an electronic system. In the previous 12 months staff reported 788 incidents. This figure excluded pathology and MRI, which we report on in the outpatients and diagnostic imaging core services.

Specialist staff and the senior team shared learning with their staff about never events that happened elsewhere. For example, they reviewed and updated insulin management processes following learning from a never event elsewhere.

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 identified learning from previous incidents that triggered the duty of candour, such as an incident in theatre that resulted in an emergency transfer.

Staff met to discuss the feedback and look at improvements to patient care based on themes of incident investigations. The senior team identified 37 categories of incident in the previous year, amongst which 101 incidents related to unplanned readmissions, return to theatre, or emergency and urgent transfers out.

Staff received feedback from investigation of incidents, both internal and external to the service. They demonstrated a good understanding of key learning from incidents and how this led to changes in procedures. For example, the team changed response protocols to deteriorating patients following an incident in which a sick patient waited over five hours for an emergency ambulance.

Staff used the incident reporting and investigation framework for near misses. We reviewed a root cause analysis (RCA) of a near miss in theatres. The process was evidence based, thorough and found good practice amongst the theatre team. For example, the team had followed all World Health Organisation processes and had reacted immediately when they realised the near miss was about to occur. The RCA found no learning that could have avoided the near miss and instead the team used it as good reflective practice and recognition that their abort system worked to protect people from harm.

Is the service well-led?

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

Leadership

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

Surgery

The hospital director and the head of clinical services, also known as the matron, led the day to day operation of the hospital. The hospital director was the registered manager. A ward manager and theatre manager led their respective areas and teams and this model was the same in each core service clinical area. Senior staff at provider level supported the hospital leadership team through quarterly meetings and site visits. The medical director was based at provider level.

Staff spoke positively about support from the matron and said they were regularly present in the department and easy to reach for support and advice.

The provider had a structured support programme for line managers across all departments. This helped staff new to leadership to access appropriate support and the resources needed to effectively lead their teams.

Leaders supported staff to develop and progress through a leadership development programme and access to training. This included national vocational qualifications (NVQs) specialist training specific to individual roles.

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.

The provider had an overarching purpose, to drive better health nationally, that guided all care and treatment. A strategic intent, guiding principles, and strategic aims, underpinned by organisational enablers, formed the guiding strategy for 2022 – 2030. The strategy focused on the charitable structure of the organisation and the ethos of holistic, sustainable care.

Empowered, confident, supported staff were a key element of the strategy and the senior team promoted the importance of their role. Staff told us they felt part of the provider's strategy and understood how it applied to this hospital and their department. Each member of staff made an individual pledge to the purpose and identified their role in making a healthier nation. Staff we spoke with were positive about this approach and told us it made them feel part of a wider purpose to deliver better care and holistic support in the region.

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.

The provider's strategic aims included elements that reflected an open, honest, and transparent working culture. A key element of the provider's care and work ethos was 'humans-first' and to deliver care that positively impacted the public and not only those who directly received care.

The hospital senior team had invested considerable time in establishing support and feedback processes for staff following learning from listening events. This included facilitating access to an independent reporting organisation that could be used anonymously. Posters around the hospital encouraged staff to "be bold" and speak to colleagues or senior staff if they had concerns. Two Freedom to Speak Up Guardians were available in the hospital. They provided staff with confidential points of contact to raise issues or concerns. Staff told us they felt there were plenty of options to talk about worries and they had access to the provider's whistleblowing policy.

Surgery

The provider was a registered charity and facilitated a working culture that recognised and rewarded social impact and community and staff inclusion. The charity team maintained regular communication with hospital staff, who were supported to participate in activities outside of their clinical roles. For example, the provider had established a programme of inclusion events in September 2022 for National Inclusion Week. This engaged staff in topics such as confidence in diversity and inclusion conversations and understanding neurodiversity. Topics helped staff to understand professional boundaries and demystified the topic of inclusion to make it accessible for everyone.

The provider had a clear focus on objective-setting as a tool to support staff development and wellbeing in the workplace. At the time of our inspection, over 85% of staff had successfully set and made progress towards objectives.

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.

Nineteen individuals formed the medical advisory committee (MAC), which met quarterly. Members reflected representation across all surgical and medical specialties and diagnostic imaging. We report on the MAC in this core service although its work covered all hospital clinical activity. The MAC ensured compliance with statutory and regulatory duties, such as ensuring the service was compliant with the Competition & Markets Authority Private Healthcare Market Investigation Order (2014).

The committee reviewed all aspects of practising privilege arrangements, which meant consultants worked within a safe treatment framework with senior team assurance. The MAC reviewed changes to national guidance and legislation and ensured changes were implemented in the relevant department. Minutes showed us attendance was consistent, reflected the range of specialties offered in the hospital, and resulted in improvements to care.

The quality and governance lead worked with the secretaries of external consultants to improve the consistency and quality of referral and care documentation. This was part of a programme to improve compliance with provider standards following instances of consultants proceeding with care planning without supplying documentation to the hospital. The lead ensured the hospital did not accept elective care for patients whose consultants did not supply compliant documentation and worked with the MAC to establish working relationships that met provider standards.

The senior team maintained up to date records of consultants and surgeons working under practising privileges. This included the most recent disclosure barring service (DBS) checks, General Medical Council (GMC) registration renewal dates, and a record of valid indemnity insurance. All clinicians were up to date with provider requirements at the time of our inspection. The system proved effective in ensuring clinicians who did not maintain expected standards were not able to deliver patient care. For example, when a consultant had not maintained their registration with the Information Commissioner's Office (ICO), the MAC removed their ability to practice until it was renewed.

The quality and safety committee met quarterly and was supplemented with a series of specialist committees that met quarterly or biannually. This included a clinical governance committee and medical devices committee.

The senior team used a live dashboard to monitor governance. The system tracked complaints, incidents, and staffing issues such as vacancies and any issues in the practising privileges system.

Surgery

Within the surgery services, each team out of recovery and anaesthetics, the ward, and the theatres, held quarterly whole-team meetings. Minutes showed us the meetings were well attended and enabled staff to keep up to date with the hospital and provider.

Management of risk, issues and performance

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

The MAC monitored National Institute for Health and Care Excellence (NICE) guidance updates and worked with specialist teams to maintain best practice. For example, they worked with the antimicrobial stewardship (AMS) team to implement policy updates when NICE identified a risk of antibiotic resistance that would impact patient risk and care. The team responded with new risk assessments and pre-surgical screening to reduce the risk of patient infection. This reflected responsive, dynamic practice and was evidence of effective risk management.

The incident reporting system was connected to the risk register. Where staff identified themes and trends, they worked within the governance framework to identify new risks needed to be included in the register.

The senior team were pragmatic in their approach to risk management. They maintained a register of issues, risks, and opportunities that incorporated a risk register balanced with more general issues and opportunities for improved care. This approach met the provider's responsibilities in relation to risk management and promoted the documentation of opportunities such as the implementation of new technology to improve patient outcomes.

In July 2022 there were 21 open risks. Staff understood their local risks. In surgery, this included carpeting in some clinical areas, which was due for removal, and a need to further embed new fire safety procedures.

Key risks related to the availability of consultants working under practising privileges and clinical staff vacancies. The team had identified an increase in length of stay for hip and knee patients between June 2022 and August 2022. This was attributed to increased demands on consultants, an increase in the use of agency nurses, and staff retirement. Plans were in place to address these areas and meeting minutes indicated a responsive approach to risk mitigation.

Quarterly meeting minutes indicated the board maintained good oversight of all areas of care and treatment. They reviewed quality and safety reports, performance based on patient feedback and outcomes, and the hospital director's report. This included appropriate decision-making around consultant practising privileges and coordination of the risk register. The board was specific to this hospital and while members maintained knowledge of work at other hospitals in the provider's network, they were focused on this site. This system supported senior clinical staff in driving changes to service provision and clinical care standards, such as by ensuring suppliers and other providers upheld contractual obligations.

Clinical governance policies were effective at identifying provider-level risks that applied to this hospital. For example, in July 2022 the team identified a lack of central policy for sepsis risks and unanswered concerns raised with the provider about deficiencies in the conscious sedation policy. They also documented concerns with the resuscitation policy as it did not fully meet up to date national guidance. The local team noted repeated escalation to the provider for a resolution and were awaiting a response.

The head of clinical services led a monthly hospitals quality and safety report. In the previous 12 months, this found overall safety compliance of 92%.

Surgery

The senior team had implemented a range of learning following reviews of the business continuity plan (BCP) following disruption that included power supply failure, water supply failure, and intruder alarms. Learning resulted in improved emergency response protocols and more in-depth training for in-charge staff out of hours.

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.

All staff completed Information governance and cyber security training. At the time of our inspection, 96% of staff were up to date. The training included the provider's policies and standard operating procedures.

The information governance committee met quarterly and included representation from departments across the hospital. The committee reviewed standards of practice, incidents from other providers, and ensured all staff were up to date with expected requirements.

All staff could access audit and performance data and policy documents, which were stored digitally. Consultants and surgeons used patient outcome data to tailor clinical practices and the pharmacy team ensured national safety information was cascaded across all relevant teams.

Between June 2022 and September 2022, staff reported five information governance incidents. The committee reviewed incident reports and investigations and worked with staff to implement improved practice. The standardisation of care records with external consultants was planned to significantly improve standards of information governance.

The hospital was accredited by the National Joint Registry as a Quality Data Provider in recognition of consistently high standards of data submission and quality.

Engagement

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

The service was demonstrably embedded in the local community and regional health system. Staff organised a continual engagement programme that included GP educational events and medical events open to the public. The team advertised events through the hospital's social media channels and posters in building.

Public events were focused on common health problems experienced by patients. Clinical specialists, such as consultants, led sessions designed to demystify health problems, promote good recovery, and build relationships between the health community and the local population.

GP educational events were multidisciplinary and attracted a range of health professionals. In 2022 attendees included physiotherapists, osteopaths, dispensing opticians, ophthalmologists, and staff from GP surgeries across the region.

The provider had an overarching engagement programme, the Nuffield Health Way. This promoted a holistic vision of health for people in the region that included care and treatment as well as health and wellness promotion. This was a structured, clearly defined programme that encouraged and enabled people in the local area to engage with the health improvement opportunities offered by the hospital and provider services regionally.

Surgery

The senior team organised regular forums in which staff from all departments could attend open meetings to discuss experiences, concerns, and suggestions for improvement. They acknowledged improved standards of practice and recognised individuals and teams through communication networks. For example, in early 2022 the senior team recognised the pharmacy team for achieving consistent 100% 'confidence and trust' scores from colleagues.

An external organisation measured staff engagement with the provider, its strategy, working conditions, and the senior team using an ongoing programme of feedback. This enabled the senior team to monitor staff morale in real time and provide support in specific areas such as expectations of provider support and work to improve workplace equity. The overall workplace satisfaction score indicated room for improvement compared with other hospitals in the provider's network.

The hospital organised a biannual patient focus group that engaged former and current patients in an interactive feedback activity to help drive consistently and high levels of patient satisfaction.

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.

The surgery team had a strategic plan to introduce a 'productive operating theatre' (TPOT) model of working. This was a piece of work focused on visionary practice and aimed to maximise the safety of patient-centred care in the theatre environment. TPOT was an evidence based programme and the team were working together to embed it into existing policies and practices to drive innovative, sustainable practice.

Clinical governance leads used a clinical scenario framework to plan services and identify and reduce risks. This provided departmental leads with tools to resolve challenges and issues using a simulated, real-time approach that was of greater value to the team than a discussion.

Work to extend infection control principles and standards were advanced and there was a significant focus on innovation and development. The infection control specialist nurse had mapped hospital standards to emerging national improvements, such as the components of national guidance to improve skin antisepsis practices using a range of research outcomes. This was part of a wider programme of work focused on the efficacy of the aseptic non-touch technique (ANTT).

Staff contributed to department-wide improvements through the range of meetings and fora available to them. For example, staff feedback led to the trial of a new type of tympanic thermometer in theatres following issues raised by the surgery team and patients. Following a successful, interactive trial, the provider implemented use of the new thermometers as a standard.

Good 

Outpatients

Safe	Good 
Well-led	Good 

Is the service 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.

Mandatory training was standardised across the hospital. Please see the surgery section for details and completion rates.

The outpatient manager worked with their team to identify specialist training to supplement the provider's mandatory programme. This included Dementia Friend training for all staff and a tissue viability course for nurses. This demonstrated how the team worked to meet the changing needs of patients.

Outpatients offered a cervical screening service, provided by trained staff. At the time of our inspection 100% of the screening team were up to date with their mandatory specialist training.

Safeguarding

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

Safeguarding procedures were standardised across the hospital. Please see the surgery section for details and for training completion rates.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service reported two safeguarding incidents in the previous 12 months. In both instances staff acted quickly, appropriately, and in line with provider standards. In one instance, staff discreetly escalated a concern about a patient with unreported prior injuries to the safeguarding team. Another instance demonstrated high standards of practice by the physiotherapy team when they had concerns about a patient's care from another service.

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.

Cleanliness and infection prevention and control (IPC) procedures were standardised across the hospital. Please see the surgery section for details of overall standards and practice.

Outpatients

IPC audits demonstrated good standards of hand hygiene practice, with 92% compliance in the previous 12 months. In the same period audits identified only 66% compliance with expected standards of equipment decontamination. The senior departmental team reviewed practices and staff training to address this area for improvement.

Outpatients reported one surgical site infection in minor surgery. This occurred in dermatology and the resident medical office (RMO), consultant, and nursing team reviewed the patient's care plan as part of the investigation.

We observed good standards of practice with the endoscopy 'bedside clean' process as part of national guidance for the safe use of flexible endoscopes.

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 was not fully in line with national guidance. Two clinical consultation rooms were carpeted, which did not reflect best practice. Staff implemented risk mitigation strategies including steam cleaning and the relocation of services that presented a risk of blood or other fluid spillage or that involved injections.

A gym equipped with specialist equipment such as an exercise stress bike was available in the hospital. Physiotherapists proactively incorporated the gym into rehabilitation care planning. Gym equipment was maintained under insurance and maintenance agreements with suppliers and manufacturers and the department lead maintained oversight of this.

Resuscitation trollies were available in the main outpatient department and adjacent to the physiotherapy gym. These included the most recent Resuscitation Council UK guidelines and staff documented daily and weekly compliance checks.

The team had updated local stock storage processes and evacuation guidance for staff following feedback from training and a simulated evacuation.

The hospital had endoscope decontamination facilities on site, which including an electronic tracking system that met national standards.

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

Risk procedures were standardised across the hospital. Please see the surgery section for details of overall standards and practice

Staff responded quickly to emerging risks to specific groups of patients. For example, during a severe heatwave, staff recognised the risk of dehydration amongst patients living with dementia. Staff prepared information and advice displays in the department and prepared 'confusion packs' to help patients and carers manage the risks associated with the heatwave. Staff assessed patients for hydration needs as part of risk assessments.

Outpatients

Staff used a series of breast care clinical risk pathways to refer patients to more advanced treatment centres based on individual need. This included for radiotherapy, chemotherapy, or immunotherapy. The breast care team used the national Breast Care Now fertility pathway and referred pre-menopausal women at risk of losing their fertility to a specialist gynaecology service. The service had links with a local clinical psychologist specialising in breast oncology and a palliative care service.

The RMO acted on pathology concerns when blood test results were outside of the expected range. They initially acted on behalf of the treating consultant to ensure patients received an immediate response and then discussed ongoing care with the medical team.

Consultants used a version of the World Health Organisation (WHO) surgical safety checklist modified specifically for outpatients. The service included this in the audit data presented in the surgery section.

Chaperones were available on request and posters around the department reminded staff and patients about this.

Staff completed comprehensive risk assessments in patient notes, including for venous thromboembolism (VTE) and waterlow after minor 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.

Staffing processes were standardised across the hospital. Please see the surgery section for details of overall standards and practice.

Outpatient staffing reflected the diverse range of services offered. Consultants led most medical specialties with nurse support. A sports medicine consultant worked with physiotherapists to deliver a sports therapy programme.

The service had enough nursing and support staff to keep patients safe. The outpatient manager was a registered nurse and worked clinical shifts. Two senior staff nurses worked across outpatient services and staff nurses and healthcare assistants (HCAs) provided support as needed across specialties. Two trainee nurse associates were based in the department and provided support within the scope of their role.

A bank gynaecology specialist nurse was working with the outpatient manager and their team to develop the gynaecology cancer service.

Records

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

Patient notes were comprehensive, and all staff could access them easily. The service was working on a full integration of paper and digital notes across each medical specialty. Urology was the first service to complete this process and the outpatient manager was working with consultants to complete the remainder. The service noted challenges in establishing a standardised approach due to the wide range of working practices between consultants, which impacted their ability to provide consistent standards of documentation.

Outpatients

Records we looked at included holistic notes from the multidisciplinary team, including comprehensive notes from allied health professionals who provided recovery and rehabilitation care.

When patients transferred to a new team, there were no delays in staff accessing their records. Consultants and physiotherapists provided detailed discharge notes and onward referrals where patients would benefit from extended community care.

Outpatient records were based on specific care pathways, such as for wound care. They included physiological measurements and meant staff balanced record standards between consistent records and individual needs.

Medicines

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

Medicines processes were standardised across the hospital. Please see the surgery section for details of overall standards and practice.

Staff followed systems and processes to prescribe and administer medicines safely. The outpatient medicine storage was secured with restricted access. Consultants prescribed medicines and nurses dispensed them in accordance with the provider's policy.

Staff audited medicines management quarterly. The most recent results from September 2022 indicated 100% compliance with provider standards.

The service used a prescription pad (FP10) tracking system to mitigate the risk associated with multiple consultants writing prescriptions. The systems required a named nurse to sign out FP10 sheets to consultants, track their serial numbers, and sign the pad back in with a cross-check of the sheets used. This reflected a good standard of safe practice. The outpatient manager audited keypad access for Controlled Drugs (CDs) in addition to the provider's usual controls. This ensured CDs were managed safely.

Incidents

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

Incident processes were standardised across the hospital. Please see the surgery section for details of overall standards and practice.

Managers shared learning with their staff about never events and serious incidents that happened elsewhere. For example, the head of clinical services carried out a review of local risk factors following a significant spill of a toxic chemical in another of the provider's locations. The chemical can be lethal in some conditions and the senior team used the SBAR (situation, background, assessment, recommendation) incident management tool to identify risk factors of a similar incident at this site. The review identified a range of changes needed in local practice to increase protection, including a business continuity plan for specific area of the building and fit testing for respiratory protection equipment amongst staff.

Outpatients

The pathology service reported 10 incidents in the previous 12 months. These included sampling errors, mishandled specimens, and incorrect tests. The pathology manager worked with their team and external partner organisations to improve consistency.

Is the service well-led?

Good 

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

Leadership

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

Senior leadership processes were standardised across the hospital. Please see the surgery section for details.

An outpatients manager worked clinically and led the pre-assessment and breast care services as well as providing day-to-day leadership across the department. The physiotherapy lead supported their team in specialist development and supported the expansion of the service, such as in sports medicine that was increasingly multidisciplinary in nature.

The clinical services manager visited each department, including the gym and physiotherapy, at least once per week.

The senior team promoted staff development into leadership roles, capitalising on the wide range of medical specialties to attract staff development, such as by offering development opportunities specific to that area of care. A senior staff nurse was undertaking the provider's senior leadership development programme, which the senior team used as a sustainability drive.

There was always a clinical lead and a member of the senior leadership team on call. This was an appropriate system for the nature of the service and meant staff could obtain rapid help on demand.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

Vision and strategy were standardised across the hospital. Please see the surgery section for details.

The outpatient team supplemented the provider's overarching strategic aims with a development plan aimed at expanding specialties in the department. This included reaccreditation of the breast care service, expanding the range of services for bariatric patients, and expanding the minor surgery service.

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.

We report on overarching hospital culture in the surgery section.

Outpatients

Outpatients introduced a staff forum in May 2022. This was well attended by a range of staff and aimed to build opportunities for greater joint working.

Staff were empowered to plan and explore development opportunities using approaches that resulted in learning for the wider team. For example, an outpatient nurse was working in the pre-assessment service to help develop an understanding between the two services of their key processes and challenges. This reflected a transparent learning culture.

Within the charitable, socially-focused work culture, staff had adopted champion roles and developed activities, events, and groups to support colleagues. For example, a pelvic health physiotherapist was the hospital's menopause champion and had established a support group for staff across the hospital. This helped those experiencing perimenopause, menopause, or post menopause to access support, care, and a safe space to talk. The physiotherapist launched the group on World Menopause Day, demonstrating the opportunities available for staff to build on social events and important support opportunities.

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.

Governance processes were standardised across the hospital. Please see the surgery section for details.

Outpatient, physiotherapy, and pathology meetings took place quarterly and were well attended by a range of staff including nurses, healthcare assistants, bank staff and administrators. Minutes identified a proactive approach to providing new training for staff, such as cannulation, as well as reviewing policies and standard operating procedures.

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.

Risk management processes were standardised across the hospital. Please see the surgery section for details.

The outpatient manager worked with the matron and consultants to establish performance frameworks for clinical specialties. The provider had existing frameworks and the local team adapted these to the needs of patients.

The medical advisory committee (MAC) had reach across all services and monitored challenges and risks. They had supported the senior nursing team with the implementation of two trainee nurse associate posts to support capacity and succession planning.

The service followed NHS England guidance for the national safety standards for invasive procedures (NatSSIPS) as a measure of quality and safety. The local team monitored national results with outpatient managers across the provider's network to benchmark practice.

The endoscopy service was JAG (Joint Advisory Group on GI Endoscopy) accredited, which meant it had been assessed to meet nationally benchmarked standards of practice.

Outpatients

Information Management

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

Information management processes were standardised across the hospital. Please see the surgery section for details.

The outpatient information governance audit, including physiotherapy, found an average 96% compliance with provider standards in the previous 12 months. The team identified more consistent computer screen locking as an area for improvement as well as more accurate handling of initial triage and referral information.

Engagement

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

We report on overarching engagement in the surgery section.

Staff recognised trends or changes in patient needs and took steps to make sure access to care and communication was equitable. For example, a member of staff prepared Makaton signs of the week for their colleagues to aid non-verbal communication. This was in response to staff recognising a need for more diverse avenues of communication.

The number of teenagers in the department had significantly reduced since the hospital suspended its dedicated children and young people service. However, outpatients and physiotherapy still provided care to teenagers and staff had recognised a persistent increase in the wider needs with which this patient group presented. The matron identified gaps in local provision for teenagers seeking advice on sexual health, alcohol and drug use, and relationships. They researched services in the area and liaised with a local organisation to provide a dedicated quiet resource space in the department. All staff we spoke with were aware of this initiative and physiotherapists in particular noted the value the work provided to their work with teenagers.


Learning, continuous improvement and innovation

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

The team's strategy for service development was focused on wider regional health considerations and staff had developed an evidence base for gaps in service provision. For example, the team was working with medical consultants to identify surgical procedures that could be carried out on a minor operations procedure in outpatients. This aimed to reduce waiting times and recovery times as patients could be treated using less invasive treatments in the minor procedure environment.

The service had achieved BUPA accreditation for breast cancer care, which reflected the team's commitment to quality and innovation.

Diagnostic imaging

Safe	Good 
Well-led	Good 

Is the service safe?

Good 

We rated safe as good.

Mandatory training

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

Mandatory training was standardised across the hospital. Please see the surgery section for details and completion rates.

Radiographers completed radiation protection training in addition to the clinical mandatory training programme and were up to date at the time of our inspection. Mammographers completed health assessment training as part of their holistic care provision and all members of the team were up to date.

Staff carried out regular cardiac arrest simulation training in the CT and MRI units. There was evidence of thorough post-simulation reviews by the senior team, which they used to improve standards of care. Such simulation training is best practice as a result of learning internationally from incidents in which patients experience cardiac arrests whilst inside imaging machinery.

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.

Safeguarding procedures were standardised across the hospital. Please see the surgery section for details and for training completion rates.

Staff were proactive in accommodating patient's safeguarding needs. For example, they coordinated care with external services for a patient with complex needs who required a hoist for some types of scan.

The ultrasound service reported one safeguarding incident in the previous 12 months. Documentation indicated staff had escalated the situation quickly and appropriately and the team demonstrated a good standard of coordinated care.

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.

Diagnostic imaging

Cleanliness and infection prevention and control (IPC) procedures were standardised across the hospital. Please see the surgery section for details of overall standards and practice.

Diagnostic imaging staff carried out a monthly hand hygiene audit specific to the service. In the previous 12 months they found 80% compliance with provider standards. The senior team was supporting refresher training and more frequent spot checks to improve practice.

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. Each diagnostic modality took place in a dedicated area with clear safety signage in place. This included illuminated, high impact ionising radiation signage and magnetic safety signage for appropriate services.

The service complied with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R). This included physically and distinctively separate areas and pathways for patients based on whether they were undergoing scans with or without ionising radiation.

Staff carried out daily safety checks of specialist equipment. Each item of diagnostic equipment had its own safety and maintenance checklist issued by the manufacturer. Staff had completed all checklists we looked at and escalated problems to the maintenance team or manufacturer promptly.

The service had suitable facilities to meet the needs of patients. Emergency procedures were in place for each imaging room that enabled staff to stop scans and move patients out of equipment. Staff undertook simulated training for the evacuation of patients from the MRI scanner, such as for a fire evacuation or in the event of a medical emergency.

The service had enough suitable equipment to help them to safely care for patients. External engineers supplied a handover form following repair or maintenance directly to department staff. This ensured local staff had details of the work carried out and assurance this was in line with provider standards.

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. They maintained anaphylaxis equipment in the MRI and CT suites to respond quickly to patients who experienced a reaction to contrast injections. Staff documented daily checks of the equipment.

Staff completed risk assessments for each patient on arrival using the most appropriate tool for their scan. This included a check of medical history to identify potential contraindications for some type of imaging or contrast injections. Some imaging required tests or risk assessments in advance. For example, staff obtained blood test results for patients in advance of a CT scan to ensure they were safe to receive contrast. The team maintained a record of allergies and other issues such as high blood pressure whilst patients were in the department in case their care needed to be escalated.

Diagnostic imaging

Staff worked within national guidance regarding safe imaging processes. For example, they carried out MRI scans with contrast only if the patient had been protocolled by a radiologist. Radiographers were trained to protocol non-contrast scans. Protocols are a predetermined set of scanning sequences designed to ensure the scan accurately captures the needed information.

Staff used a world health organisation (WHO) safety checklist to deliver complex care. The senior team audited this and in the past 12 months the team achieved 100% compliance with expected standards.

Staff shared key information to keep patients safe when handing over their care to others. Diagnostic imaging was typically a component part of a wider care plan or clinical investigation. This meant staff were involved with patient care for a relatively short period and then handed results to other professionals. Clinical documentation sharing was structured to reflect this system and ensure treating clinicians had access to appropriate risk assessments and other documentation.

Shift changes and handovers included all necessary key information to keep patients safe. Staff worked with colleagues in surgery and outpatients to ensure seamless care. Radiographers provided an in-theatre diagnostics service and worked with surgeons and nurses to coordinate care.

Staff used established processes for unexpected findings. They escalated urgent findings or sinister pathology to the referring consultant or GP, or to the RMO depending on the patient's treatment pathway.

Physiotherapists and sports medicine staff referred patients to imaging services within defined protocols. Those who had completed IR(ME)R competencies could refer patients to ionising radiation services such as X-ray. External sports medicine specialists referred patients with prior approval from the hospital to ensure they were appropriate and clinically indicated.

Most staff were trained as chaperones and all patients were offered this service.

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. A team of 18 specialist staff delivered diagnostic imaging services, including radiographers, a radiology assistant, a hospital assistant, a healthcare assistant, and administrators.

A breast care nurse specialist, one mammographer and two bank mammographers were part of the team and provided the mammography service.

The imaging manager planned staff levels in advance based on demand and expected need from the surgery team.

Most staff in the department were cross-trained to work between modalities. The X-ray service was an exception and had a staffing team that worked only in that service. This was an appropriate structure and supported reliability and high standards of safe practice.

Sixteen radiologists from an NHS trust had agreements with the hospital and referred patients for MRI and ultrasound sounds. They sent protocols to the local imaging team who carried out the scans.

Diagnostic imaging

A medical consultant held a weekly 30 minute 'on demand' slot for diagnostics that enabled their patients to access rapid imaging during their outpatient appointment.

Radiologists carried out reporting from most scans and a specialist musculoskeletal (MSK) radiologist reported from films on site.

An X-ray radiographer was on call 24/7 for inpatients. The resident medical officer (RMO) made out of hours decisions about X-ray needs and ensured patients underwent imaging in a timely manner.

Records

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

Patient notes were comprehensive, and all staff could access them easily. The team used electronic systems, including the picture archiving and communications system (PACS) and the clinical record interactive search (CRIS), to document, store, and transfer scans and reports. Both systems were national standards and readily accessible by referring services. Staff used paper records for some processes, such as protocols and prescriptions. A project was underway to digitise the remaining hard copy systems.

Records were stored securely. Electronic systems used encrypted systems with appropriate back-ups and protection from cyberattacks.

As part of annual IR(ME)R safety and quality processes, staff audited a sample of 10 patient records in each diagnostic speciality. The most recent audit took place in August 2022 and found consistently good standards. In each record checked, staff had completed clinical information sufficient for the scan, documented an ID check, recorded radiation dose details and the designated 'entitled practitioner' had signed the scan report in each case. This reflected practice that met national guidance.

Medicines

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

A limited number of medicines were used in diagnostic imaging, including contrast, Buscopan, and Furosemide. The pharmacy team was working with the imaging team to digitise the prescribing and recording system across modalities.

The radiology senior leadership team out audits of medicines management to ensure compliance with IR(ME)R and prescribing guidance. The audit consistently found full compliance with expected standards, including in the storage and risk management of contrast.

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.

Diagnostic imaging

Incident processes were standardised across the hospital. Please see the surgery section for details of overall standards and practice.

Staff reported 18 incidents in the previous 12 months, of which 15 related to imaging documentation errors. One incident involved an incorrect scan. The senior team debriefed and supported staff after incidents and worked with them to identify opportunities for learning. This had recently included supporting staff following a patient who was abusive during a pre-scan risk assessment.

Incident investigations demonstrated staff responded appropriately. For example, during an MRI equipment alarm they escalated the problem using the standard operating procedure and adjusted the service to make sure patients were not at risk.

Most incidents were not related directly to imaging equipment and instead to issues such as slips, trips, and falls.

Is the service well-led?

Good 

We rated well-led as good.

For vision and strategy and engagement, please see 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.

Senior leadership processes were standardised across the hospital. Please see the surgery section for details.

A national diagnostic imaging manager provided on-demand support centrally and visited the hospital regularly. In the hospital, the imaging manager worked across all modalities and ensured staff had the support and resources they needed. Diagnostic imaging staff told us they were happy with local leadership arrangements and said they were supported in their roles, which gave us assurance of a well-run department.

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.

We report on overarching hospital culture in the surgery section.

Senior department staff used a patient-centred staffing model across their teams. This meant they worked with counterparts across the hospital to coordinate staff availability that met patient's needs. For example, they increased staffing levels where the surgical ward was planned to be busy and when certain outpatient specialties were in session. Imaging staff spoke positively of this and said they appreciated the culture of working closely with other professionals across the hospital.

Diagnostic imaging

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.

Governance processes were standardised across the hospital. Please see the surgery section for details.

All radiologists had current General Medical Council (GMC) registration, indemnity insurance, a recent disclosure barring service (DBS) check and evidence of compliance with the information commissioner's office (ICO). The medical advisory committee (MAC) maintained oversight of this information as part of the governance process for clinical staff working under practising privileges.

Staff used up to date local rules for all imaging. These were stored in each scanning room in hard copy and staff also had digital access. Governance systems worked effectively to identify opportunities to improve or advance practice. For example, the senior time was preparing a policy to enable non-radiologists to provide ultrasound.

The diagnostic imaging quality lead, head of quality, medical director, radiation protection advisor (RPA), MRI safety expert, and ultrasound advisor formed the radiation protection committee. The committee met annually and reviewed national safety alerts, policy changes, and local hospital incidents and performance. They reviewed adverse events across the provider nationally, including reportable incidents, and minutes demonstrated learning was applied to each hospital team.

Imaging staff attended a cross-modality quarterly meeting to facilitate communication and ensure they were up to date with provider policies and work.

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 quality lead for diagnostic imaging and MRI safety expert led risk management in the service. They worked with modality specialists to ensure practice met national standards and benchmarks.

The radiography team audited IR(ME)R compliance annually. This included a review of standard operating protocols in each diagnostics specialty and checks of justification guidelines in theatre fluoroscopy to ensure they met national standards. Staff acted on audit findings to improve practice. For example, the most recent compliance results found a need for more consistent documentation of pregnancy checks in patients undergoing a DXA scan.

The hospital had suspended its children and young people service. To meet demand safely, the diagnostics service provided services to young people over the age of 13 on a non-interventional basis and using plain scans only. This enabled the team to manage risks and provide safe standards of care.

The team planned capacity one week in advance. This mapped equipment availability with planned clinical activity and staffing levels. This process helped address service disruption and risks to care by ensuring appropriate staff were available with equipment that was ready for use.

Diagnostic imaging

The diagnostic imaging manager was the radiation protection supervisor (RPS) with support from other staff trained to deputise for them. RPSs were trained to carry out imaging reject analysis and X-ray radiation dose monitoring. This met national requirements and met the service maintained compliance.

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.

Diagnostic imaging relied on effective and consistent standards of information and data management to transmit scan images and reports to referring professionals. The information governance committee identified areas for improvement in the handling of information. A recent audit found variable quality of scans during a specific period. Incident reports identified a series of errors in information governance in relation to image labelling and recording. The diagnostic imaging manager was working with the team to identify gaps in standard operating procedures or staff training to reduce instances.

Staff paid attention to detail when checking automated information systems. For example, they identified a misalignment in the date and time recording on a bladder scanning machine and took immediate action.

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.

The diagnostics team continually looked for capital opportunities to procure the latest equipment to drive the most effective patient care. For example, the team recently introduced new equipment for CT colonography. Feedback from radiographers and radiologists indicated vastly improved image quality and patient comfort.

The MRI service had recently achieved BUPA accreditation in recognition of consistent standards of quality and safety.