Practice Plus Group Hospitals Limited

Practice Plus Group Hospital, Shepton Mallet

Inspection report

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Shepton Mallet
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Date of inspection visit: 12/4/2023, 13/04/2023, 25/04/2023
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Overall summary

We carried out an announced comprehensive inspection of the services on 12 and 13 April 2023 with further telephone interviews on 25 April 2023.

Practice Plus Group Hospital, Shepton Mallet is an independent hospital that employs around 167 clinical and support staff plus 43 administrative staff on both full and part time basis and provides care to patients in the South West of England.

The hospital provides the following services: surgery (predominantly knee and hip replacement), general surgery, ophthalmology, gynaecology, ear, nose and throat (ENT), pain management, endoscopy, outpatients, and diagnostic imaging.

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

• Diagnostic and screening procedures.

• Surgical procedures.

• Treatment of disease, disorder, or injury.

At the time of inspection, the hospital had a registered manager.

A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The hospital was previously inspected on 11, 12, 13 and 26 October 2016 when the hospital was operated by a different legal entity and managed by a different organisation. It was rated as outstanding overall with ratings of outstanding for all five key questions.

Following this inspection our overall rating of this service was good.

Surgery:

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

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept accurate care records. Staff knew how to report patient safety incidents.
- Staff provided good care and treatment and gave patients enough to eat and drink. Managers monitored the effectiveness of the service. Staff worked well together for the benefit of patients. Surgical services were routinely available six days a week. Audits were comprehensive, meaningful, and acted on.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions.

Summary of findings

- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait for treatment. Staff went above and beyond to make adjustments to help meet the needs of individual patients.
- Leaders had the skills and abilities to run the service and were visible and approachable. They supported staff to develop their skills and take on more senior roles. The service had a vision for what it wanted to achieve. Staff at all levels were clear about their roles and accountabilities. Risks were recorded effectively and monitored. Governance systems worked well.

However:

- Data used to give assurance of overall mandatory training compliance was incomplete.
- Staff competencies were monitored using a spreadsheet and it was not clear when staff had undergone their competency checks or when they were due to be re-checked.
- Patient feedback response rates from some areas, including post anaesthetic care, was poor.
- Staff were not always made aware of all relevant information about patients before admission to help facilitate safe and effective care and treatment.
- Not all patients received a Malnutrition Universal Screening Tool (MUST) assessment as part of their preoperative and preadmission assessments.
- Some staff felt meetings could be intimidating and centred around a blame culture when changes to processes had not gone smoothly.

The previous rating included a joint rating for outpatients and diagnostic imaging service, we have rated them independently as part of this inspection.

Outpatients:

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

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

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

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. Staff knew how to report patient safety incidents.
- Staff provided good care and treatment and gave patients enough to eat and drink. Managers monitored the effectiveness of the service. Staff worked well together for the benefit of patients. Services were routinely available six days a week. Audits were comprehensive, meaningful, and acted on.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders had the skills and abilities to run the service and were visible and approachable. They supported staff to develop their skills and take on more senior roles. The service had a vision for what it wanted to achieve. Staff at all levels were clear about their roles and accountabilities.

Summary of findings

However:

- Not all staff within the Ophthalmology and Outpatients Department were compliant with mandatory training.
- There was not suitable secure storage for staff clothing in the ophthalmology department.
- There was not oversight of the quality of data and systems used to monitor mandatory training compliance.
- Not all risks were recorded effectively and monitored.

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

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

Diagnostic imaging:

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

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

We rated it as good because:

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

However:

- Not all staff were up to date with their safeguarding adults training.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	We rated it as good because: • The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. Staff knew how to report patient safety incidents. • Staff provided good care and treatment and gave patients enough to eat and drink. Managers monitored the effectiveness of the service. Staff worked well together for the benefit of patients. Surgical services were routinely available five days a week. Audits were comprehensive, meaningful, and acted on. • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. • The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait for treatment. Staff went above and beyond to make adjustments to help meet the needs of individual patients. • Leaders had the skills and abilities to run the service and were visible and approachable. They supported staff to develop their skills and take on more senior roles. The service had a vision for what it wanted to achieve. Staff at all levels were clear about their roles and accountabilities. Risks were recorded effectively and monitored. Governance systems worked well. However: • Data used to give assurance of overall mandatory training compliance was incomplete. • Staff competencies were monitored using a spreadsheet and it was not clear when staff had undergone their competency checks or when they were due to be re-checked.

Summary of findings

- Patient feedback response rates from some areas, including post anaesthetic care, was poor.
- Staff were not always made aware of all relevant information about patients before admission to help facilitate safe and effective care and treatment.
- Not all patients received a Malnutrition Universal Screening Tool (MUST) assessment as part of their preoperative and preadmission assessments.
- Some staff felt meetings could be intimidating and centred around a blame culture when changes to processes had not gone smoothly.

Outpatients

Good 

Outpatients is a large proportion of hospital activity. The main service was Surgery. Where arrangements were the same, we have reported findings in the Surgery section.
We rated this service as good because it was safe, caring and responsive. We rated well led as requires improvement. We do not rate effective.
Our rating of this location went down. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. Staff knew how to report patient safety incidents.
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- Leaders had the skills and abilities to run the service and were visible and approachable. They

Summary of findings

supported staff to develop their skills and take on more senior roles. The service had a vision for what it wanted to achieve. Staff at all levels were clear about their roles and accountabilities.

However:

- Not all staff within the Ophthalmology and Outpatients Department were compliant with mandatory training.
- There was not suitable secure storage for staff clothing in the ophthalmology department.
- There was not oversight of the quality of data and systems used to monitor mandatory training compliance.
- Not all risks were recorded effectively and monitored.

Diagnostic imaging

Good

Diagnostic imaging is a small proportion of hospital activity. Surgery was the main proportion of hospital activity. Where our findings on surgery, for example, management arrangements, also apply to other services, we do not repeat the information but cross-refer to the surgery service.
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- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. They provided emotional support to patients, families and carers.

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- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

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Summary of findings

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Background to Practice Plus Group Hospital, Shepton Mallet

Practice Plus Group Hospital, Shepton Mallet is operated by Practice Plus Group Hospitals Limited.

The hospital is in a semi-rural area in Shepton Mallet, Somerset. The hospital is sited adjacent to an NHS community hospital and within a building leased from NHS Property Services. The hospital provides surgery and outpatients and diagnostic imaging services to NHS patients, private patients and primarily serves the communities of Somerset.

Surgery services provide non-urgent surgery for adults who meet strict eligibility criteria to include being over the age of 18 years. Services delivered include orthopaedics, general surgery, ophthalmology and endoscopy, ear, nose, and throat (ENT), gynaecology, urology, fracture management and pain management.

There are four theatres with normal operating sessions from Monday to Friday between 8.00 am and 4.00 pm and optional sessions on Saturdays from 8.00 am to 4.00 pm. Theatre 1 is for ophthalmology with capacity for emergency ophthalmic procedures. Theatre 2 is for general surgery, gynaecology, ENT, urology, and minor (non-joint space) orthopaedic procedures; this theatre has capacity for emergency surgical procedures. Theatres 3 and 4 are laminar flow orthopaedic theatres for major joint replacements, upper limb hand and shoulder, foot and ankle, and other orthopaedic procedures; these theatres have the capacity for emergency orthopaedic procedures. A fifth theatre was a dedicated suite providing colonoscopy, gastroscopy, sigmoidoscopy, and cystoscopy. Normal operating sessions are on Monday to Friday from 8.00 am to 5.00 pm with optional operating sessions available on Saturdays from 8.00 am to 5.00 pm.

There are eight recovery bays and 10 admission / discharge bays. There is a dedicated Central Sterilised Service Department (CSSD) through which all equipment trays are sterilised except for heavy orthopaedic sets, which are currently outsourced.

The inpatient ward has 25 beds, which are in the format of two / three bedded rooms with en-suite facilities, personal bedside telephones, TVs, and free access to Wi-Fi.

Patients access the service at Practice Plus Group Hospital Shepton Mallet through referral by their GP, optometrist, musculoskeletal service or acute NHS trust and if eligible, are seen in the outpatient clinic before an appointment is arranged for surgery.

The hospital also provides outpatient, physiotherapy and diagnostic imaging services to patients referred for treatment. Referrals are accepted from GPs and via the choose and book patient choice system and are clinically triaged by the Pre Admissions Team to ensure the patients met the criteria for the service. Children or young people under the age of 18 are not treated in the departments.

The outpatients department sees patients from all specialties available within the hospital such as ear, nose, and throat (ENT), general surgery, orthopaedic surgery, urology, ophthalmology, gynaecology, ear, nose and throat (ENT) and pain management. The physiotherapy service provides a service to both inpatients and outpatients. They do not take external referrals and only see patients having treatment at the hospital.

Summary of this inspection

The diagnostic imaging department provides plain X-rays, ultrasounds, ultrasound guided injections and MRI (Magnetic Resonance Imaging) scans to patients attending the hospital. Referrals for MRIs are also taken from musculoskeletal services.

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

How we carried out this inspection

The inspection team consisted of 1 inspection manager, 1 medicines inspector, 3 inspectors and 3 specialist advisors with expertise in surgery, outpatients and diagnostic radiography who carried out a site visit over the 12 and 13 April 2023.

The inspection was overseen by Catherine Campbell, Deputy Director of Operations.

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

During the site visit we met and spoke with patients and staff.

For surgery, we spoke with 18 staff and 6 patients and reviewed 7 patient records.

For outpatients, we spoke with 15 members of staff and 5 patients.

For diagnostic imaging we spoke with 7 members of staff and 10 patients.

We spoke with 4 people from the senior management team including the Hospital and Medical Directors. We also reviewed 4 personnel files, 3 complaints and 5 serious incident investigations.

We spoke to the Director of Nursing remotely in the week after the inspection.

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

Outstanding practice

We found the following outstanding practice:

Surgery:

- The service had purchased a specialist translation electronic device with instant access to over 200 interpreters who were available by phone and video call with British sign language also available by video link.
- The service had access to a selection of blood tests on the ward to aid with assessment both preoperatively and in an emergency.

Summary of this inspection

Areas for improvement

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

Action the service MUST take to improve:

Outpatients:

- **The service MUST** improve recording and monitoring risks in the ophthalmology department. (Regulation 17 (2) (b) (d)).
- **The service MUST** improve the quality of the data and systems used to monitor mandatory training compliance. (Regulation 17 (2) (b) (d)).

Action the service SHOULD take to improve:

Surgery:

The service SHOULD improve the quality of the data and systems used to monitor mandatory training compliance.

The service SHOULD ensure staff undertake safeguarding training in line with company policy, best practice guidance and legal responsibilities.

The service SHOULD collect patient feedback from all areas of the service to help drive improvements.

The service SHOULD make sure staff have access to all relevant information about patients before they are admitted for surgery.

The service SHOULD ensure all patients who require a Malnutrition Universal Screening Tool (MUST) assessment receive this before admission.

The service SHOULD ensure all actions and recommendations from external reviews and panels are completed and document evidence to support this.

The service SHOULD consistently and clearly monitor staff competencies with clear dates for review.

The service SHOULD encourage blame free culture and address perceived intimidating behaviors at all levels.

Outpatients:

The service SHOULD ensure all staff are compliant with mandatory training.

The service SHOULD ensure staff undertake safeguarding training in line with company policy, best practice guidance and legal responsibilities.

Summary of this inspection

The service SHOULD ensure staff undertake mental capacity act and deprivation of liberty safeguard training in line with company policy, best practice guidance and legal responsibilities.

The service SHOULD ensure suitable secure storage for staff clothing in the ophthalmology department.

The service SHOULD ensure the laser register in ophthalmology is stored in a locked cabinet.

Diagnostic imaging:

The service SHOULD ensure all staff are compliant with mandatory training.

The service SHOULD ensure staff undertake safeguarding training in line with company policy, best practice guidance and legal responsibilities.

The service SHOULD consider the reconfiguration of the waiting area to ensure patients can be observed by reception staff.

The service SHOULD consider training for staff on the effects of static magnetic field as outlined under the Control of Electro Magnetic Fields at Work Regulations.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Is the service safe?

Good

We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and most staff had completed it. However, data used to give assurance all staff were up to date with their training was incomplete.

Nursing and medical staff received and kept up to date with their mandatory training. Data submitted showed 95% compliance with all mandatory training subjects at the time of our inspection across all staff groups throughout the hospital. However, across all non-medical staff and departments we found data for 24 staff had not been included in the data when calculating overall compliance.

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

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia. Staff completed training on the Mental Capacity Act and could give examples of where they escalated concerns around patient mental capacity.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However not all staff had received up to date training on how to recognise and report abuse.

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

Staff received specific training on how to recognise and report abuse and we saw they completed level 2 training in safeguarding adults and children. The surgical ward manager was trained to level 4 in safeguarding adults and children.

Staff gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010. We reviewed their safeguarding policy which was in line with the latest legislation.

Staff received training specific for their role on how to recognise and report abuse. Most staff were up to date with safeguarding adults (100%) and children (95%) level 2 training at the time of inspection. However, of the staff required to undertake safeguarding level 3 for adults and children 81% were compliant across all staff employed in all clinical areas.

Staff followed safe procedures for children visiting the ward.

Cleanliness, infection control and hygiene

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

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

The service generally performed well for cleanliness. The cleaning assurance audits for February and 2023 showed 91.2% compliance with national standards. For the same period the cleaning assurance audit for theatre showed only 76.7% compliance. However, we saw external factors and actions taken were noted. A further ward environmental audit showed 83.3% compliance and showed specific actions were fed back to the housekeeping team.

Weekly cleaning audits were completed in theatres, monthly in other areas. These were shared with the Infection, Prevention and Control (IPC) lead for the service. Any problems were rectified immediately and shared with the team.

The service had developed a detailed infection prevention and control induction programme for clinical staff.

Staff used records to identify how well the service prevented infections. This was discussed at monthly clinical governance meetings and covered any infection, prevention, and control concerns. Deep cleaning of surgical areas was completed every 6 months. This was carried out by an external contractor. The next deep clean was booked for May 2023. If an outbreak occurred or a patient had an infection, they would organise an urgent deep clean.

The service monitored post-surgical infection rates, investigated them, and reported them to all relevant external bodies. Between November 2022 and February 2023, the hospital reported 1 deep infection, 3 superficial infections, 5 suspected infections, 3 patient reported and 1 abscess. This was in line with the infection rates reported across other Practice Plus hospitals.

The service routinely screened new admissions for *Methicillin-resistant Staphylococcus aureus* (MRSA). Specific questions were asked as part of the pre-operative checklist around historical positive MRSA tests. If a patient had tested positive, they were referred back to the consultant for follow up and further tests if necessary. In addition, and in response to a local outbreak of Carbapenemase Producing Enterobateriaceae (CPE) at a local NHS trust, all patients who had received any care or treatment at this trust were screened for this bacterium.

The service managed and decontaminated reusable medical devices in line with national guidance such as the Department of Health Technical Memorandum on decontamination. Some sterile surgical equipment was provided by a third-party supplier, but we saw staff assessing all equipment prior to use.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed consistent PPE compliance in theatres and on the ward. The service managed externa contractors visiting theatres by using a QR code. Contractors and medical representatives scanned the code on arrival which indicated their vaccination status and gave assurance to the hospital they were safe to enter clinical environments.

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

Staff worked effectively to prevent, identify, and treat surgical site infections. Four dedicated cleaners were ward-based between 8 am to 6 pm each day.

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

Environment and equipment

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

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

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

Staff carried out daily safety checks of specialist equipment, this included resuscitation trolleys and equipment required for surgery. Staff were encouraged to raise any faults. Engineers were introduced to carry out repairs, other improvements included air conditioning installation in a medicine storeroom.

The service managed and decontaminated reusable medical devices in line with national guidance such as the Department of Health Technical Memorandum on decontamination. Some sterile surgical equipment was provided by a third-party supplier, but we saw staff assessing all equipment prior to use. Staff described what they would do should a problem be found with any of the kit. During our inspection an external equipment representative was present during a procedure which was being carried out for the first time. In response to the surgeon's feedback, the contents of one of the sterile kits was being changed for future procedures.

The service identified a problem with the autoclaves (equipment used to deep clean and sterilise surgical kits before use) which meant some types of kit were not compliant with the Department of Health Technical Memorandum on decontamination. Following extensive talks with the manufacturer, the service decided to replace the equipment in June 2023. In the interim, the kits identified for some of the larger orthopaedic operations were provided by an external company.

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

We requested information from the service about any recent Patient-Led Assessments of the Care Environment (PLACE) by NHS England following our inspection. This showed the hospital performed as well as and better than the England national average in all domains assessed.

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

Assessing and responding to patient risk

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

Staff used a National Early Warning Tool version 2 (NEWS 2) to identify deteriorating patients and escalated them appropriately. We reviewed 7 completed NEWS 2 checklists which confirmed that patients were closely monitored.

The service carried out a Major haemorrhage training scenario in 2021 following a major bleed post-surgery for one patient. As a result, the hospital changed its policy on transfers of patients requiring emergency blood transfusions. The hospital now immediately transferred patients to a local NHS trust for type specific blood rather than wait for the blood to be delivered to the patient before transfer.

There was a policy for transfer of patients to the nearby NHS hospital trust for emergency treatment if required. Between April 2022 and February 2023, 10 patients, out of a total of 6774 inpatient and day case procedures, were transferred to local hospital trusts for emergency treatment because of unexpected post-surgical complications. The service analysed each case to identify any potential improvements.

We observed several procedures with full completion of the World Health Organisation (WHO) surgical safety checklist by theatre staff. Following our inspection, we requested WHO checklist audit data from November 2022 to February 2023. We received information which showed 100 % compliance.

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

Following sepsis scenario training in November 2022, sepsis boxes had been introduced on the ward with a protected stock of emergency medications which followed the Somerset best practice guidelines which had been developed by a local NHS trust.

Staff knew about and dealt with any specific risk issues. The service held 3 scheduling meetings per week to discuss each patient and their individual needs around 3-4 weeks before their surgery was due. We reviewed their exclusion policy which included children and pregnant women. Patient records included checklists for potential risks such as sepsis, venous thromboembolism, falls and pressure ulcers.

Not all patients received a Malnutrition Universal Screening Tool (MUST) assessment prior to admission. Senior staff explained that whilst there were exclusion criteria for patients with a body mass index (BMI) over 40, there needed to be a greater focus on patients with a low BMI as this could directly impact both their suitability for surgery and their recovery period.

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

Good

Surgery

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

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

Nurse staffing

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

At the time of our inspection, the service had a very low vacancy rate for registered nurses of 0.45% and 1.65% for healthcare assistants. Also, the service had a rolling 12-month turnover of 13.71% and a sickness rate of 1.42%

The service utilised bank staff who were existing employees and had a low agency nurse usage. Managers made sure all bank and agency staff had a full induction.

At the time of our inspection the service had 3 healthcare assistant vacancies, 4 nurse vacancies, 2 anaesthetic practitioner vacancies and 1 scrub practitioner vacancy.

The service had enough nursing and support staff to keep patients safe. The number of nurses and healthcare assistants for shifts we reviewed matched the planned numbers.

Nurse staffing was closely monitored on their risk register.

During the 3 scheduling meetings per week, managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

They adjusted staffing levels daily according to the needs of patients. Cover was provided for staff absence and managers requested bank and agency staff who were familiar with the service.

Medical staffing

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

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

The service employed 21 doctors which equalled 13.6 full time equivalent posts.

At the time of our inspection, the service had 4 consultant vacancies.

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

Good

Surgery

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

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

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

Records

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

Patient notes were comprehensive, and all staff could access them easily. Patient notes were a combination of electronic and paper form and contained the patient's surgical pathway, each consisted of a list of daily medicines, risk assessments, NEWS 2 and multi-disciplinary records.

Records were stored securely. Paper records were stored securely in locked filling cabinets on the ward, electronic records were password protected.

Documentation audits were undertaken monthly. Following our inspection, we reviewed the most recent documentation audit from February 2023 (ward audit) and March 2023 (theatre audit). For the ward audit, one record was audited which showed 100% compliance against criteria assessed. For theatres, out of 10 patient records reviewed, the service achieved 97.6% compliance.

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

Medicines

The service used systems and processes to safely prescribe, administer, and record medicines. Medicines were stored correctly.

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

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

We reviewed 7 patient records which showed staff completed medicines records accurately and kept them up to date.

Good

Surgery

Audits showed staff were aware of safety alerts, stock rotation and incidents to improve practice. However, during our inspection we found one out of date item, which was removed from use once flagged.

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 met to discuss the feedback and look at improvements to patient care and there was evidence that changes had been made because of feedback.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We saw records were thorough and contained evidence of actions and learning. We reviewed 3 incidents and saw the recommendations after the 48-hour call to discuss the incident, the actions taken and the owner of the action plan and the timescale.

Staff knew what incidents to report and how to report them. Staff described the process for reporting all incidents and received feedback from managers. In the 12 months leading up to our inspection the surgical division reported 105 incidents.

All incidents were reported directly onto the incident reporting system. This provided a single record of each incident, subsequent investigation, agreed learning, and evidence of the learning and its effectiveness.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The incident reporting policy set out the processes for reporting and managing incidents and described the root cause analysis investigation process and the roles and responsibilities of staff involved in the process.

Managers shared learning with their staff about serious incidents and never events that happened elsewhere in the group during monthly clinical governance days. The service reported no never events in the 12 months prior to our inspection.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if, and when things went wrong.

The duty of candour process clearly outlined what to do and who was responsible for taking action. We saw examples where this had been applied.

Managers shared learning about never events and serious incidents with their staff and across the organisation.

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

Staff received feedback from investigation of incidents, both internal and external to the service and from other centres in the Practice Plus group.

Feedback was shared with staff after reporting an incident and an action plan was shared. Learning from incidents started at the point where the event happened, with any necessary local action being taken to minimise a similar event from reoccurring.

Good

Surgery

Learning was shared using a variety of methods. Firstly, there was an immediate response and any local action taken to help prevent a reoccurrence and formal feedback methods such as team meetings to help spread any learnings from events.

Is the service effective?

Good

We rated it as good.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. However, some staff told us they had met resistance to some proposed changes to bring the service in line with some current national guidance.

The service undertook several service improvements in line with the National Institute for Health and Care Excellence guidance to achieve best outcomes for patients, such as promotion of physiotherapy before surgery to achieve quicker recovery. The service achieved 100% compliance with National Joint Register reporting.

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

Staff protected the rights of patients subject to the Mental Health Act 1983 and followed the Code of Practice, although the service did not usually treat these patients.

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

Nutrition and hydration

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

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

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

Staff fully and accurately completed patients' fluid and nutrition charts where needed. We reviewed 7 patient records which showed consistent recording of food and fluids given to patients.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. If catering staff noticed a patient was not eating or drinking, they would inform nursing staff. However, the initial assessment on admission was not consistently being completed. Between January and March 2023 78.9% of patients received an assessment. We did not see any actions recorded to improve this.

Patients waiting to have surgery were not left nil by mouth for long periods. However, one patient told us they had fasted for 12 hours prior to their surgery and was offered tea and biscuits post procedure. However, staff clarified the required fasting period was 6 hours.

Pain relief

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

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

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

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

Patient outcomes

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

The service participated in relevant national clinical audits supported by an audit schedule.

Outcomes for patients were positive, consistent, and met expectations, such as national standards.

The service had a lower-than-expected risk of readmission for elective care than the England average. Between October 2022 and March 2023, 7 patients were re-admitted within 30 days of discharge.

Managers shared and made sure staff understood information from the audits.

The service submitted relevant data to external organisations such as Patient Report Outcome Measures (PROMS). This is a measure of health gain in patients undergoing hip or knee replacement surgery and is completed using a survey before and after surgery. Return rates for PROMS forms between October 2022 and March 2023 were 98.3% for hip replacements and 98.7% for knee replacements. The service reported an issue with an external company responsible for interpreting the data and had not received scores from the patient outcomes for several months. Managers explained they were looking at alternative companies to provide this data in future. Following our inspection this problem had been rectified and all data had been submitted.

The service also monitored Oxford hip and knee scores (a numerical measure of improvement). The most recent data from March 2023 showed the number of patients who reported an improvement in Oxford knee replacement surgery was 92.05% and Oxford hip replacement surgery was 80.43 %.

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

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. However, data collected to monitor compliance was confusing.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers explained they approached training in a holistic way which took account of staff life circumstances. Managers supported staff to access training which worked with their individual circumstances.

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

Managers made sure staff received any specialist training for their role. All staff underwent a comprehensive professional competency checklist upon appointment.

Ward staff competencies were monitored using a spreadsheet; however, this was confusing and contained data going back to 2009. It was not clear when staff had undergone their competency checks or when they were due to be re-checked.

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

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. Patient requirements were discussed at weekly planning meetings along with ensuring an adequate staffing skill mix.

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

Managers supported all staff to develop through yearly, constructive appraisals of their work. The service was 99.9% compliant with annual staff appraisals. Staff said that managers were supportive and encouraged them to develop their skills. Performance issues were overseen centrally by a specialist team covering recruitment, educational training, and performance management.

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

Managers said that most consultants were employed purely by the service and did not work at local hospital trusts.

Multidisciplinary working

Good

Surgery

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

Service managers held meetings 3 times per week to discuss planned surgery admissions and allocated resources appropriately. Discharge planning was discussed during weekly MDT meetings to ensure that all aspects of patient care was considered and did not delay their recovery.

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

The hospital did not have a cancer specific service.

Seven-day services

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

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

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

Health promotion

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

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

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff made sure patients consented to treatment based on all the information available.

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

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

Good

Surgery

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act 1983, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

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

Following our inspection, we were provided with training data that confirmed 94% of staff were compliant with combined Mental Capacity Act and Deprivation of Liberty Safeguards training.

Is the service caring?

Good

We rated it as good.

Compassionate care

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

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

During our inspection we observed positive interactions between staff and patients. Staff were open, friendly, and approachable and interactions were very caring, respectful and compassionate.

Care from the nursing, medical staff and support staff was delivered with kindness and patience. The atmosphere was calm and professional, without losing warmth. Staff were focused on the needs of the patients and ensured they felt respected and valued as individuals.

Patients said staff treated them well and with kindness. The service collected monthly patient and family feedback, results from March 2023 showed that 98.8% of patients rated their experience as good.

The comments we received from patients were unanimously positive. They spoke positively about their experience in the hospital from staff at the front door, the reception staff, consultants and nurses, and housekeeping staff. They confirmed the staff were kind and helpful to them. During the inspection we observed a patient waiting to have physiotherapy. We saw staff providing reassurance, talking with them and keeping them updated about what would be happening.

Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed a nurse ask a patient if they could check their dressing and explained to them what they would be doing. They also used this time to speak with the patient about any pain or discomfort they may be experiencing.

Support was available for patients with hearing or visual impairment, or who were living with dementia or learning disabilities.

We saw patients being treated with dignity and respect. Voices were lowered and curtains were used to avoid confidential or private information being overheard. All patients said their privacy and dignity was maintained.

Staff followed policy to keep patient care and treatment confidential. We saw patient handovers were facilitated away from patient bays to maintain confidentiality.

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

We saw numerous examples of staff providing reassurance to patients who may need additional support. For example, talking to patients about their concerns about the speed of their recovery and walking with patients who may have mental health needs to ensure their safety and minimise any distress.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Emotional support

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

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

We saw staff providing emotional support to patients. Individual concerns were promptly identified and responded to in a positive and reassuring way.

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

Patients were spoken with in an unhurried manner and staff checked if information was understood. Staff talked about patients compassionately and with knowledge of their circumstances and those of their families. A patient told us they felt well looked after and their needs were fully met, with additional support provided for personal care.

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

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. We observed staff showing empathy to patients about their condition and the impact that this had on their lives.

Understanding and involvement of patients and those close to them

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

Good

Surgery

Staff made sure patients and those close to them understood their care and treatment and supported patients to make informed decisions about their care.

Patients said all procedures had been explained and they felt included in the treatment plan and were well informed. We observed staff explaining the process by which nurses carried out regular checks such as positioning, pain and personal care.

The ethos of putting patients first ensured patients and their families were well informed about the risks or benefits of treatment to enable them to make decisions about their care and treatment.

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

We saw staff explaining things to patients in a way they could understand. Staff were aware of the types of communication aids that could be used to support patients. Staff were clear about how to access interpreting services and where to go for additional support if needed. Patients told us staff were clear when speaking with them and they could understand what care and treatment was being provided.

Staff showed understanding and a non-judgmental attitude when caring for or talking about patients with mental health needs, learning disabilities and dementia. We saw a patient being supported in their choice of treatment. The individual was provided with information about the types of treatment available and why a certain treatment would be beneficial. Staff knew how to access advocacy services and supported patients to achieve this when required.

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

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

All patients we spoke with were positive about the service they had received. One patient told us their care had been “exceptional” and another that the nurses and doctors had been “very professional”, and their experience had been “incredible – first class.” Patients said the food was “wonderful with lots of choice” and the hospital chef visited daily to discuss requirements. Some patients said if they felt hungry, they could choose a larger portion and could have “extras, like a hot meal, fruit, sandwiches or cheese and biscuits.” However, one patient told us they would have liked to have been offered something more substantial than biscuits following a day case procedure.

Patients gave consistently positive feedback in postal and on-line surveys. Friends and family test feedback from February 2023 showed 100% of inpatients rated their experience as good with an 82.3% return rate. However, the post anaesthetic care unit (PACU) did not have any response for the same period. Since our inspection, the service submitted data to show that between April 2023 and June 2023, some areas had increased their patient survey return rate by over 200%.

A new patient feedback coordinator started in December 2022 and data for March 2023 showed 98.8% of patients who provided feedback about their care rated it as good. However, it was not possible to see which areas or wards this feedback had been collected from.

Is the service responsive?

Good

Surgery

Good

We rated it as good

Service delivery to meet the needs of local people.

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

Managers planned and organised services, so they met the needs of the local population. We observed scheduling meetings that took place up to 3- 4 weeks before planned surgery.

Facilities and premises were appropriate for the services being delivered.

The service relieved pressure on other departments and NHS trusts by undertaking some types of blood tests on the wards. Managers had identified that sending blood test to a nearby NHS trust increased the chance of delaying discharge so had purchased specialist equipment to allow staff to undertake some blood test on the wards.

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

Managers ensured that patients who did not attend appointments were contacted and took action to minimise missed appointments.

Meeting people's individual needs

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

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

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

Staff supported patients living with dementia and learning disabilities by using a 'This is me' patient passport. This was given to the patient in the outpatient department and stayed with them throughout their patient journey. This enabled patients to submit details about themselves and their likes and dislikes to ensure staff were aware of their preferences.

There was a dementia lead who had undertaken dementia training along with other staff on the ward and from the outpatient department. Staff liaised with the local NHS hospital and other partners to obtain this information before surgery took place and discussed in scheduling meetings. However, staff told us they were not always told if a patient had additional needs before they were admitted.

Good

Surgery

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

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

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

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

Access and flow

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

Managers monitored waiting times and made sure most patients could access services when needed and received treatment within agreed timeframes and national targets. Data submitted showed that in February 2023 40% of patients had waited longer than 18 weeks for their procedure. Data submitted after the inspection showed the average wait for surgery across all specialties was 19.3 weeks. The longest waits were in ear, nose, and throat (26.5 weeks) and the shortest waits were in gastroenterology (5.3 weeks).

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. Data submitted showed that in January 2023 and February 2023 there had been 1 delayed discharge.

Between April 2022 and March 2023, the service completed 6774 surgical procedures on behalf of the NHS and privately funded patients.

Managers worked hard to keep the number of cancelled operations to a minimum. In the 12 months leading up to our inspection, the service had cancelled 156 operations. Of those operations, 124 were cancelled for clinical reasons and 32 were cancelled for non-clinical reasons. In the 12 months prior to our inspection, when patients had their procedures cancelled, data showed that for non-clinical cancellations 75% were re-booked within 28 days.

Scheduling meetings took place 3 times a week, which included a review of the previous week's theatre lists and a preview of the week ahead. The meeting was attended by all departments in the hospital and was chaired by the hospital director. Discussions included equipment ordered, any reasonable adjustments, bed capacity, clinical requirements, support for the ward, any safety alerts and staffing levels.

Managers and staff worked to make sure patients did not stay longer than they needed to. To minimise the number of hospital visits, diagnostic scans were made for the same day as pre-admission assessment and the hospital had purchased equipment to carry out some types of on the day blood tests.

Managers and staff worked to make sure that they started discharge planning as early as possible. Discharge planning started at the pre-admission appointment, which included information about their post-operative recovery.

Good

Surgery

Learning from complaints and concerns

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

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. There was a focus on improving the quality and timeliness of complaint responses within the group. During complaint investigations staff were required to provide comments, and when indicated, written statements.

There were policies and processes to appropriately investigate, monitor, and evaluate patient's complaints. The policy stated the roles, responsibilities, and processes for managing complaints.

Complaints were initially responded to within 3 days by telephone or email depending on patient preference, and a full response was sent by the hospital director or medical director within 20 working days. There was weekly contact with the complainant to advise progress.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers told us patients and their families were also invited to face to face meetings.

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

Staff could give examples of how they used patient feedback to improve daily practice.

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

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was made to improve the service.

Most complaints related to communication problems between the teams across the hospital. We saw evidence of learning from complaints and an action plan following an Independent Sector Complaints Adjudication Service (ISCAS) referral, however, not all actions had been completed. Following our inspection, the service submitted further evidence to show all actions had now been completed.

Complaint numbers were monitored. In the 12 months prior to our inspection, the service received 16 formal complaints.

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

The service was a member of the Independent Sector Complaints Adjudication Service (ISCAS) which provided independent analysis on complaints for ISCAS subscribers. ISCAS was a voluntary subscriber scheme, used by most providers of independent healthcare. The service had one complaint go to adjudication in December 2022.

Good

Surgery

Is the service well-led?

Good

We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. However, some staff did not always feel completely supported.

Leaders had the skills, knowledge, experience, and integrity that they needed. Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. However, whilst some staff felt supported to raise concerns, they did not always see action as a result.

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

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

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

At the time of inspection, the hospital had a registered manager.

There were clear priorities for ensuring sustainable and effective leadership. The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service. For example, they encouraged staff to attend a nationally recognised leadership management programme.

Vision and Strategy

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

There was a clear vision and a set of values, with quality and sustainability as the top priorities. The service had a realistic strategy and supporting business plans to achieve its goals.

The hospital embraced the corporate group vision alongside service and leadership charters.

Good

Surgery

There was a robust, realistic strategy for achieving the priorities and delivering good quality sustainable care. Services had been planned to meet the needs of the relevant population. Each department or service had an individualised set of goals centred around the objectives of people, performance and growth. Progress against delivery of their strategy was monitored and reviewed at regular intervals during clinical governance and hospital manager meetings.

The vision, values and strategy had been developed using a structured planning process in collaboration with staff, people who used services, and external partners.

Staff were aware of and understood the vision, values and strategy and their role in achieving them.

Progress against delivery of the strategy and local plans was monitored and reviewed.

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. However, some staff reported bullying culture in some meetings.

Staff felt respected, supported, and valued. They were proud to work for the service. The hospital was calm, professional and organised.

We reviewed staff survey results from 2022 where 67% of staff had completed the survey. 97% of staff believed that the service embraced diversity and 98% of line managers treated staff as individuals.

The culture was centred on the needs and experience of people who used services. Actions taken to address behaviour and performance was consistent with the vison and values, regardless of seniority. However, some staff felt some meetings could be intimidating and centred around a blame culture when changes to processes had not gone smoothly or changes made to enhance patient safety through referral criteria.

Staff told us they were able to raise issues, and this was acted on.

Leaders, managers, and staff acted on behaviour and performance consistent with the vision and values. The hospital demonstrated openness, honesty and transparency when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.

Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed. The service had access to a Freedom to Speak Up Guardian.

The service had core expected values and behaviours for the organisation and their staff. These, along with the services objectives and vision, were incorporated into performance reviews. The organisation's values were rated for each individual staff member to identify areas of development.

There were mechanisms for providing all staff at every level with the development they needed, including high-quality appraisal and career development conversations. There was a strong emphasis on the safety and well-being of staff. Staff incentives included two free meals a month and a Practice Plus Group excellence awards scheme.

Good

Surgery

The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff we spoke with felt they were treated equally.

Staff had received unconscious bias training to enable them to identify any bias which may affect the way patients were treated.

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

Governance

Staff had regular opportunities to meet, discuss and learn from the performance of the service. Staff at all levels were clear about their roles and accountabilities. However, leaders did not always operate effective governance processes. Data was consistently submitted to external organisations as required.

There were effective structures, processes, and systems of accountability to support the delivery of the strategy and good quality, sustainable services. The service had a golden thread running through its objectives which was reflected in both overarching and service level objectives.

We reviewed 4 staff electronic files and saw recruitment processes and checks, sickness records, training revalidation, occupational health adjustments and appraisal records.

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

Monthly clinical governance meetings included a review of allocated actions, alongside an emphasis on training and learning. There were department meetings, heads of department meetings, quality, and governance meetings.

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

There was not effective governance and oversight of training performance. Managers monitored monthly training and acted if any areas showed non-compliance. However, data we reviewed which was used to give assurance of overall training compliance was incomplete. 24 out of the 116 had not been included in the report used to calculate overall training compliance.

We reviewed information supplied by the service to the Private Healthcare Information Network (PHIN) including volume of patients, length of stay, patient feedback, infections, consultant reference, health improvements, never events and incidents. However, we reviewed the PHIN website and found there was insufficient data provided by the service to display.

Management of risk, issues, and performance

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

Good

Surgery

The organisation had assurance systems and performance issues were escalated through clear structures and processes. A system of visual safety pin alerts had been devised to better draw staff attention to visual key safety messages.

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

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

We reviewed department and overall service risk registers. The top three risks included the new electronic records system, data quality and pharmacy staffing. The service used a visual risk heat map to highlight changing areas of risk.

Potential risks were considered when planning services, for example, seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities.

Impact on quality and sustainability was assessed and monitored. There were no examples of where financial pressures had compromised care.

Information Management

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

Information was used to measure improvement as well as to gain assurance. Quality and sustainability both received coverage in relevant meetings at all levels. The service had developed a comprehensive quality improvement programme.

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

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

There were arrangements to ensure data and notifications were submitted to external bodies as required.

Engagement

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

Good

Surgery

People's views and experiences were gathered and acted on to shape and improve the services and culture. The service had consistently good patient and staff feedback.

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

The service was attempting to reinstate a patient forum group (PFG) to enable a two-way dialogue between the provider and patients regarding elements of the patient experience. Managers explained this had existed before COVID-19, but had not yet been re-formed.

The service had a chosen charity of the year. Fundraising took place throughout the year with lots of activities planned such as cake sales.

Staff survey results showed 67% of the workforce were engaged and had completed the survey. The top 3 questions related to acting with integrity (98%); embracing diversity (97%); and manager engagement (91%).

The bottom 3 questions related to pay and benefits (41%); senior managers encourage staff to discussed organisational goals (60%); senior management empowering organisational goals (61%).

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

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

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

Staff received several benefits including a monetary bonus, 2 free lunch passes per month, a free pantry, free feminine sanitary products, and onsite parking.

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

Learning, continuous improvement and innovation

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

Leaders and staff aspired to continuous learning, improvement, and innovation. For example, the service had purchased a specialist translation electronic device with instant access to over 200 interpreters who were available by phone and video call. British sign language was available by video link.

Good

Surgery

There service used an innovative approach to patient blood tests. Staff explained sending out blood samples to a nearby NHS hospital could take up to 2 hours to return and were delaying discharges. In addition, staff explained that having access to troponin tests (a hormone measured when a patient is suspected of having a heart attack) or HbA1c (an average blood glucose reading used to monitor diabetes control) helped in both emergency situations and assessment of patients for surgery.

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

The service had developed a 'grow your own' staff development programme to internally develop, upskill and promote staff.

Good

Outpatients

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

Is the service safe?

Good

We rated it as good.

Mandatory training

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

The mandatory training was comprehensive and met the needs of patients and staff.

80% of outpatient, therapy and ophthalmology staff had completed an appropriate level of resuscitation training.

Clinical staff completed training on recognising and responding to patients with learning disabilities, autism and dementia. There was conflict resolution training.

However, 72% of outpatient staff including therapy staff and assessment and triage staff (23 out of 32) had met the mandatory training compliance target of 95%. 57% of ophthalmology staff (4 out of 7) had met the training compliance target.

Managers monitored mandatory training and alerted staff when they needed to update their training. However, staff told us access to a computer in the outpatient department was limited and the volume of patients through every department meant it was difficult to find time to complete the training. Across all non-medical staff and departments we found data for 24 staff had not been included in the data when calculating overall compliance.

Safeguarding

Staff we spoke with understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had completed training on how to recognise and report abuse.

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

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

Staff gave examples of how they had identified adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff followed safe procedures for children visiting the service /department.

However, nursing staff had not completed training specific for their role on how to recognise and report abuse. 60% of eligible outpatient, therapy and ophthalmology staff (12 out of 20) were not in date for safeguarding adults level 3 training.

36% of eligible outpatient, therapy and ophthalmology staff (10 out of 28) had not completed safeguarding children training.

During our inspection there had been an issue with the reporting system not capturing some training records. There was a plan for this training to take place. We reviewed the most up to date training records and found a lack of oversight of training compliance.

Cleanliness, infection control and hygiene

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

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

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

Handwash gels were available at sinks. The hospital had an infection prevention control link nurse. The handwashing audit showed 96.3% compliance in March 2023.

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. However, space in the outpatients department was limited. The ophthalmology department did not have signage for visually impaired patients, storage for staff belongings, or a welcoming waiting area for patients.

Staff carried out daily safety checks of specialist equipment. The service had enough suitable equipment to help them safely care for patients. The cleaning of equipment audit showed 100% compliance in March 2023.

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

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

The outpatient department was limited in size. This meant patients were seen in areas such as post anaesthesia care unit (PACU) for pre assessment and group and screen clinics. We were told by staff that this was intimidating for patients at their initial appointment.

Good

Outpatients

The service had enough suitable equipment to help them to safely care for patients. There was access to emergency equipment in the diagnostic corridor.

The physiotherapy department had one office, a room in the outpatient department and one room in the community hospital one day a week. The office space was also used for storage. The department had recently recruited an occupational therapist (OT) to specialise in hand surgery.

The ophthalmology department had moved to a premises which had been converted from a ward in the community hospital. There were no signs for visually impaired patients and the paving slabs leading to the department were broken and posed a trip hazard. These issues were raised during the inspection and work to rectify commenced immediately. There was no waiting room for patients, however chairs were available in the corridor. One treatment room had been redecorated. There was a staff toilet that was also being used as a changing room. This room had boxes on the floor and staff clothes draped over them due to no staff lockers available within the department.

Assessing and responding to patient risk

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

Staff responded promptly to any sudden deterioration in a patient's health.

Staff completed risk assessments for each patient on arrival, using a recognised tool. Staff knew about and dealt with any specific risk issues. We were told of an example when a patients relative accompanied the patient to a pre-assessment appointment and was unwell. The staff recognised the relative was in septic shock and referred them to receive treatment at the local NHS Trust immediately.

The ophthalmology department had an eye triage form. If patients called the department with symptoms, the call taker was able to determine what required immediate clinical attention and what could be actioned with 12 or 24 hours.

Staff knew about and dealt with any specific risk issues. For example, reporting sepsis and venous thromboembolism (VTE) risk of developing a blood clot.

Staff arranged referrals for patients to receive specialist mental health support. Staff had details of the mental health crisis helpline.

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

There was a daily morning team brief where key information was shared.

The ophthalmology department ensured compliance with the five steps to safer surgery, World Health Organisation (WHO) surgical checklist. Monthly audits of the WHO checklist for cataract surgery were completed. From records we saw 100% compliance from December 2022 to March 2023.

Staffing

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

Good

Outpatients

The outpatient department had enough nursing and support staff to keep patients safe. There was the equivalent of 6.2 whole time equivalent nursing staff. This included a manager, lead nurse, 6 additional registered nurses and 4 bank nurses. There was the equivalent of 5.2 whole time equivalent healthcare assistants. There were 8 healthcare assistants (HCA), 2 bank HCAs and 1 bank assistant practitioner (AP). There was 1 plaster technician and 2 coordinators. Managers adjusted staffing levels according to the needs of patients and devised a rota one week in advance. Cover was provided for staff absence and managers requested bank staff. Agency staff were not used.

In March and April the ophthalmology service recruited a nurse, nursing assistant, optometrist and a HCA. They were undergoing their induction during our inspection. This meant the department had 9.2 whole time equivalent staff. There was still an administrative staff vacancy for the department which was out for recruitment.

Records

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

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

Records were stored securely. Paper records were stored securely in locked filling cabinets on the ward, electronic records were password protected.

Completion of records was regularly audited and actions were taken to address any shortfalls. A pre-operative documentation audit was completed regularly. Compliance on 5th March 2023 was 100%.

However, the laser register in ophthalmology was not stored in a locked cabinet. This was

highlighted during the inspection and rectified immediately.

Medicines

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

For our main findings please refer to the surgery report.

The department did not routinely prescribe medicines. Nurses had completed patient group direction training (*Patient Group Directions* (PGDs) provide a legal framework that allows some registered health professionals to supply or administer specified medicines) for patients that required pupil dilating eye drops. Staff followed systems and processes to prescribe and administer medicines safely.

Staff completed medicines records and stored prescribing documents safely.

Incidents

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

Good

Outpatients

For our main findings please refer to the surgery report.

Staff knew what incidents to report and how to report them. There had been a total of 49 incidents reported in outpatients between March 2022 and March 2023. Staff raised concerns and reported incidents in line with the service's policy. Staff received feedback from investigation of incidents. The service had reported no never events.

Managers shared learning with their staff about never events that happened elsewhere.

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

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

There was evidence of improvements made following incidents in the outpatient and ophthalmology departments. For example, a policy had been devised for the management of a non-patient in the event of a collapse or medial emergency following an unwell relative.

Is the service effective?

Inspected but not rated

We do not rate effective.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Care, treatment and support was delivered in line with legislation, standards and evidence-based guidance, including the National Institute for Health and Care Excellence (NICE) and other expert professional bodies, to achieve effective outcomes.

The service used policies, care and treatment pathways, and clinical protocols and processes. Policies were available to all staff on the intranet system and staff demonstrated they knew how to access them.

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

Nutrition and hydration

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

The outpatient department and waiting area was situated next door to the hospital's cafeteria. The ophthalmology department did not have refreshment facilities for patients. However, patients waiting for long periods were given a voucher to use at the hospital cafeteria.

Good

Outpatients

Pain relief

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

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

Patient outcomes

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

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

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

Competent staff

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

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

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

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. The new ophthalmology team had completed an eye anatomy course, additional role specific courses and attended clinics in other hospitals to gain experience. Staff told us they felt supported and the learning was done at their own pace. Some staff were signed as competent for the treatment of wet macular degeneration (wet macular degeneration (AMD) is a long-lasting eye disorder that causes blurred vision or a blind spot in the central vision). Treatment included an intravitreal injection (an intravitreal injection is an injection of a drug into the vitreous body (the jelly in the eye) these medicines help stop bleeding and leaking from blood vessels in the back of the eye).These procedures were signed off by a consultant ophthalmologist or specialist AMD practitioner.

Multidisciplinary working

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

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

The department provided one-stop clinics so patients could see all the health professionals involved in their care on the same day. If patients were eligible for surgery, they were able to book their appointment on the same day. A member of the booking team was situated in the outpatient department to complete this.

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

Good

Outpatients

Seven-day services

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

Staff could call for support from doctors and other disciplines within the hospital. The service operated six days a week from 7:30am to 5pm with clinics on Saturdays. The Ophthalmology ran clinics Monday to Friday.

Health promotion

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

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle. Nursing staff told us the importance of offering support and advice to lead healthier lives. For example, we observed staff signpost patients to their general practitioner (GP) for blood pressure monitoring.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained verbal and written consent from patients for their care and treatment in line with legislation and guidance.

Staff made sure patients consented to treatment based on all the information available and clearly recorded consent in the patients' records.

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

However, during our inspection, 47% of clinical staff in the outpatient department and 57% of ophthalmology staff had not completed up to date mental capacity act and deprivation of liberty safeguard training.

Is the service caring?

Good

We rated it as good.

Compassionate care

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

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

Good

Outpatients

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

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

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients were spoken with in an unhurried manner and staff checked if information was understood.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

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

Understanding and involvement of patients and those close to them

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

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

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

Patients gave positive feedback about the service. We saw ophthalmology patients had written "The staff made me feel very relaxed and at all times kept me fully informed as to what was going on. I cannot praise your staff too much, they were brilliant" and "My grateful thanks to the ophthalmology team who looked after me when I had my eye surgery. From the moment I was admitted I was treated really well. I know that medical knowledge is important but communicating with patients is just as important and this was done very well by all the members of the team making me feel relaxed as well as looked after which I haven't felt when I've had a lot of surgery in the past". We spoke with four patients during the inspection and all the feedback was positive.

Is the service responsive?

Good

We rated it as good.

Good

Outpatients

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the changing needs of the local population.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. Patients were able to book surgery on the same day of their preassessment appointment if they were eligible.

Facilities and premises were appropriate for the services being delivered. Patients had access to accessible parking and accessible toilets. The outpatient department ran a clinic on Saturday.

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

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

Managers ensured that patients who did not attend appointments were contacted. This was attempted on 2 separate occasions and a letter was also sent.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Patient needs were identified at pre-assessment appointments. The hospital had a dementia link nurse. Staff supported patients living with dementia and learning disabilities by using a 'This is me' patient passport. This was given to the patient in the outpatient department and stayed with them throughout their patient journey.

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

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. A hearing loop was available at reception and was portable and could be moved around the hospital.

Access and flow

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

In the last 12 months 24708 patients had attended outpatient appointments and 3780 patients had attended ophthalmology appointments. Of the 3780 patients, 3358 were NHS and 422 were privately funded patients. 955 patients had cancelled their outpatient appointments and 97 patients had cancelled their ophthalmology appointments.

Good

Outpatients

Within the ophthalmology department, appointments for cataract surgery met national targets. However, there was limited availability for glaucoma and minor eye appointments. We were told in March and April the service had recruited an optometrist, registered nurse, nurse associate and healthcare assistant and they were undergoing their induction training.

Managers and staff worked to make sure that they started discharge planning as early as possible. Discharge planning started at the pre-admission appointment, which included information about their post-operative recovery. There was a dedicated pre assessment team (PAT) that called patients to monitor and assess them whilst waiting for surgery. They also called patients 7 days prior to surgery to answer questions, advise patients of any special requirements and remind them of their arrival time.

Learning from complaints and concerns

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

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

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

Managers shared feedback from complaints with staff and learning was used to improve the service. We were informed of an example in the ophthalmology department where a patient was cancelled due to having a high body mass index (BMI). Therefore, patients' weight and height were measured during the clinic to avoid this happening again.

The outpatient department had received 12 complaints between March 2022 and March 2023.

Is the service well-led?

Requires Improvement

We rated it as requires improvement.

Leadership

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

For our main findings please refer to the surgery report.

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

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

Good

Outpatients

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

Vision and Strategy

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

For our main findings please refer to the surgery report.

Culture

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

For our main findings please refer to the surgery report.

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

Most staff told us they felt supported by their colleagues and they enjoyed working for the organisation.

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

Governance

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. However, not all leaders operated effective governance processes.

For our main findings please refer to the surgery report.

Staff were clear about their roles and understood what they were accountable for, and to whom. Managers held regular meetings and shared minutes with staff who could not attend. There were department meetings, heads of department meetings, and quality and governance meetings. There was a clinical governance day for all staff every other month with an emphasis on training and learning.

Managers were responsible for monitoring training compliance, however we did not see a plan to improve compliance rates or a risk recorded including any mitigating factors for the non-compliance.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. However, not all risks and issues had identified actions to reduce their impact.

Good

Outpatients

For our main findings please refer to the surgery report.

The outpatient department was part of the organisation's assurance systems and performance issues were escalated through clear structures and processes. A system of visual safety pin alerts had been devised to better draw staff attention to visual key safety messages.

There were some arrangements for identifying, recording, and managing risks, issues and mitigating actions. The outpatient departments risk register fed into the overall risk register for the hospital. However, the ophthalmology annexe was not featured on this document. There was a risk register for the ophthalmology department but not all risks identified were on the risk register. During our inspection there was uneven and broken paving slabs leading to the department, which were a trip hazard for visually impaired patients. We raised this concern during our inspection and work had begun to rectify this. This risk was not on the risk register for the department or hospital. The department's environment health and safety audit highlighted areas where the environment contravened The Workplace (Health, Safety and Welfare) Regulations 1992. There were no lockers available for staff in the department and their clothes were stored on cardboard boxes and there was no dirty linen trolley. We did not see how these risks were being managed.

Impact on quality and sustainability was assessed and monitored. There were no examples of where financial pressures had compromised care.

Information Management

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

For our main findings please refer to the surgery report.

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

Staff had access to information they required to provide good patient care. Staff used electronic systems to manage patient information and to gain access to information.

All staff had access to the intranet, which contained the information and guidance for staff to perform their duties. Staff we spoke with were familiar with the intranet and knew where to find the information they needed.

Engagement

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

For our main findings please refer to the surgery report.

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

Good

Outpatients

Most staff told us they felt engaged, informed and up to date with what was happening within the department and the wider hospital. Information was shared through different forums. These included emails and staff meetings. Staff meetings were held each month. Staff told us a variety of things were discussed including serious incidents and key messages from the senior management team.

Learning, continuous improvement and innovation

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

For our main findings please refer to the surgery report.

The ophthalmology department had identified the majority of post operative phone calls from patients were due to dry eyes post cataract surgery. This was causing discomfort for patients and increasing the workload for the team. As a result of this, all patients were given artificial tears when discharged from the clinic. The amount of phone calls from patients had significantly reduced.

Good

Diagnostic imaging

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

Is the service safe?

Good

We rated it as good.

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

Staff received and kept up to date with their mandatory training through a mandatory training programme. Most staff were up to date with their training or had dates booked to attend training soon and were up to date with their skills and knowledge to enable them to care for patients appropriately. Records showed 97% of staff had completed their training against a target of 95%.

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

The training programme covered a range of topics including basic life support, clinical governance, conflict resolution, equality and diversity, health and safety, infection prevention and control, learning disability and autism, medication administration and management, and moving and handling.

Staff in diagnostics completed face to face basic life support training. Most staff were compliant.

Staff completed training on recognising and responding to patients with learning disabilities, autism and dementia. Most staff had completed training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLs).

Managers monitored mandatory training and alerted staff when they needed to update their training. Performance reports were available to review training attendance and staff could check their compliance with mandatory training. Managers saw which members of their team were up to date and were able to plan when team members needed to complete refresher training. Staff told us they received an email when training was due, and their managers discussed this with them at the regular team meetings.

Training compliance was reported monthly as part of the governance report. Training compliance was also monitored centrally by Practice Plus Group Hospitals Limited.

There was evidence all staff working with radiation had appropriate training in the regulations, radiation risks, and the use of radiation and we saw from training records, modules covering Ionising Radiation (Medical Exposures) Regulations (IR(ME)R) 2017.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Most staff maintained up to date mandatory training, which included Safeguarding Adults level 3 and Safeguarding Children level 2. All staff were up to date with Safeguarding Children Level 2. However, 4 members of staff were not compliant with Safeguarding Adults Level 3. They had dates booked for future training.

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

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were knowledgeable about the safeguarding policy and procedures for making decisions about safeguarding concerns and were clear about their responsibilities.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They described what actions they would take should they have safeguarding concerns about a patient. All staff were confident to challenge to ensure the safety of patients.

We saw details of 3 safeguarding concerns raised during recent years and the actions taken.

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

There was a safeguarding lead for the hospital and a safeguarding link radiographer.

Cleanliness, infection control and hygiene

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

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

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Radiographers cleaned all equipment and the hospital's cleaning team ensured all other areas were clean and tidy and they were fully integrated with the clinical teams. There were daily schedules and weekly and monthly tasks, alongside deep cleaning as and when required.

A cleaning folder contained an infection prevention and control policy, a radiology department cleaning policy and cleaning environments standard operating procedures (SOP). There were guides covering COVID-19, radiology equipment cleaning and the storage of disinfectants.

Good

Diagnostic imaging

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

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

Regular infection prevention and control audits were completed. Results from the infection prevention control assurance audit tool showed results of 91% from October 2022 and February 2023. Audits using the hand hygiene observational toolkit showed results ranging from 100% in December to 93% in March 2023.

Precautions were taken when seeing people with suspected communicable diseases such as influenza. Where a patient was known or suspected as having a communicable disease, they were given an appointment at the end of the list to enable deep cleaning after their scan or X-ray.

Areas where radioactive materials were kept, such as the injection preparation room and the waste storage cupboards, were cleaned by clinical staff. All restricted areas including waste storage areas were visibly clean and uncluttered.

Environment and equipment

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

The design of the environment followed national guidance for safety. There were 2 X-ray rooms, MRI and ultrasound room, an office, reception area and waiting area.

The waiting area was located outside of the main radiology department and patients could not be observed from the main reception office. There were plans to add a viewing window from the office to the waiting area.

In the reception area there were wipeable chairs and information notices, and a photo board of staff. However, there were only 2 photographs with staff names displayed for the remaining members of the team.

Staff greeted patients when they rang the bell on arrival and clinicians collected patients and escorted them to the appropriate diagnostic room.

An X-ray changing room was available and the door could be locked from the inside with access to the X-ray room via a communicating door. Lockers were also available for patients to use.

The diagnostics environmental audit showed scores of 97% in December 2022, and 100% in April 2023.

We requested information from the service about any recent Patient-Led Assessments of the Care Environment (PLACE) by NHS England following our inspection. This showed the hospital performed as well as and better than the England national average in all domains assessed.

Good

Diagnostic imaging

The service had enough suitable equipment to help them to safely care for patients. There was access to emergency equipment. The emergency trolley was in the corridor. It was clean, tamper evident and ready to use. Staff conducted daily and weekly checks of the equipment and medicines to ensure they were ready to use and in date. From the records we reviewed during a three-month period there were no gaps in the log. Staff explained patients would be brought outside the MRI room into the corridor.

There was no evidence of MRI crash scenario training. However, staff said they practised quarterly and would involve the crash team once a year.

The service had suitable facilities and equipment to safely meet the needs of patients. Staff said they had access to the equipment they needed for the care and treatment of patients. They had enough space to move freely through the department. A wheelchair was available if required.

A disabled toilet was available within the department and male/female toilets were located nearby in the corridor by the waiting room.

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

Staff showed us how they monitored and stored clinical waste bags which contained radioactive waste. Staff explained radioactive clinical waste had to be stored until the level of radiation had decayed to a safe level. The waste could then be disposed of in the same way as normal clinical waste. Every bag and sharps bin disposed of was coded and records were kept of the background radiation at the time of storage and then disposal.

The service had an equipment quality assurance programme for all equipment and had input from a medical physics expert (MPE) as required by the Ionising Radiations (Medical Exposure) Regulations 2017 on optimising clinical procedures. Equipment was operated and maintained consistent with the manufacturers' recommendations.

A radiation protection advisor (RPA) was also appointed under the 2017 Regulations. The RPA conducted annual on-site audit of compliance with the regulations, provided a personal dosimetry service and advice on Medicines and Healthcare products Regulatory Agency (MHRA) safety notices. We reviewed the last audit from July 2022.

There were service contracts for equipment and a clear process for maintenance of equipment and for reporting of any faults. All tests and work on equipment were performed in accordance with professional guidance.

The service had completed risk assessments for all new or modified uses of radiation, which were reviewed every two years or whenever a change occurred.

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

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

Good

Diagnostic imaging

The service ensured controlled areas (where ionising radiation was present) were restricted to authorised personnel only. There was clear signage when ionising radiation exposure occurred with illuminated radiation signs all lit up with "DO NOT ENTER" to prevent accidental access.

The scan room was constantly observed during scanning. Patients could reach call bells and staff responded quickly when called.

The service ensured specialised personal protective equipment was available and used by staff and carers when needed. Staff showed us the syringe shields, lead screens and storage facilities for the radiopharmaceuticals.

Assessing and responding to patient risk

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

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments relating to patients needs were completed and evaluated. There were clear processes to deal with patients where their medical condition was deteriorating.

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

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

The service ensured the radiation protection advisor and the medical physics expert were easily accessible to provide radiation advice.

There were processes to ensure the right person got the right scan or X-ray, at the right time. Staff followed the Society of Radiographers "pause and check" guidance when checking patient's identity before administering injections.

The service followed the Royal College of Radiologists' Standards for the communication of radiological reports and fail-safe alert notifications. Images were uploaded to the electronic system which was accessed by the IR(ME)R licence holder or another approved reporter. Final, verified reports were automatically transferred (along with images) to the picture archive and communication system (PACS) on publication of the report.

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

The service ensured staff were aware of patients who were or may be pregnant before they were exposed to any radiation in accordance with IR(ME)R and for staff in accordance with Ionising Radiation Regulations (IRR) 2017. We saw posters displayed in patient areas telling them to speak to a member of staff before they were scanned. Pregnancy status was recorded and scanned into the electronic patient record system. The service used an inclusive pregnancy status declaration which required all patients to be asked what gender they were assigned at birth to ensure the safety of all patients of childbearing age.

Good

Diagnostic imaging

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

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

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

Staffing

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

The service had a consultant radiologist, a radiology manager, a sonographer, 4 radiographers, an apprentice radiographer, a health care assistant and 3 administrative staff. The number of staff matched the planned numbers. The manager accurately calculated and reviewed the number of radiographers needed for each shift. They adjusted staffing levels daily according to the needs of patients. Cover was provided for staff absence and managers requested bank and agency staff.

At the time of our inspection the service had 2 vacancies and new staff were joining the team imminently.

Agency and bank staff who worked for the service received a comprehensive induction and the service recorded training details for the staff centrally which aligned with mandatory training required by the service.

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

Records

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

An electronic patient administration and record system had been adapted for use in radiology. Records were comprehensive, and all staff could access them easily.

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

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

Completion of records was regularly audited and actions were taken to address any shortfalls. A diagnostics clinical practice review and documentation audit was completed regularly. Compliance with diagnostic standards ranged from 96% in August 2022 to 97% in March 2023.

Good

Diagnostic imaging

As part of the justification process to conduct exposure to radiation, the imaging service attempted to make use of previous images of the same person requiring the test. The service stored images on a wider picture archive communication system, which meant they could access previous images if the patient had been scanned at any of the group sites.

Some scans and X-rays were outsourced to a teleradiology company for reporting, which was monitored centrally.

Medicines

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

Staff followed systems and processes to administer, record and store medicines in line with the provider's policy. Staff had undertaken medicines management training.

All medicines and prescribing documents were managed and stored safely. Medicines were currently stored in a cupboard in a locked room. However, the cupboard was broken and a new one was expected in May. In the meantime, access to the locked room was restricted to authorised staff. The service did not use or store controlled drugs.

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

Staff knew how to report incidents or near misses on the electronic reporting system. Staff felt confident in raising an incident should they need to. Managers investigated incidents and shared lessons learned with the team and the wider organisation.

Staff used prefilled syringes to deliver saline flushes after administering the radiopharmaceuticals There was a patient group direction (PGD) for the administration of Gadovistou solution for injection of pre-filled syringe/cartridge.

The consultant radiologist vetted the procedure for contrast. This included the need for a saline flush of 0.9% w/v sodium chloride. By vetting the request with the use of sodium chloride it acted a prescription for the patient negating the need for a PGD.

This had been discussed with the pharmacy lead and the pharmacist on site and was deemed to be sufficient to cover the use of sodium chloride for the purpose of using it as a flush, post cannulation and post contrast injection.

The service had processes to ensure the right radiopharmaceutical and activity was sourced, prepared and injected into the correct patient. Radiopharmaceuticals were ordered in advance and according to the vetted request. Injections of radioisotopes were administered in line with the IR(ME)R operator checklist for Administration of Radioisotopes for Molecular Imaging Procedures.

The service had an Ionising Radiation (Medical Exposures) Regulations (IR(ME)R) audit schedule, which was last completed in July 2023 and was planned for its annual repeat in line with legal requirements under IR(ME)R 2017.

Incidents

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

Good

Diagnostic imaging

Staff reported serious incidents clearly and in line with the provider's policy. There was a clear policy and pathway to guide staff to identify and report incidents and investigate them appropriately. Staff were open, transparent and honest about reporting incidents and said they would have no hesitation in reporting incidents. They were clear about how they would report them. Staff said they were encouraged to report incidents promptly.

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

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

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

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation and apology when things went wrong. Although we did not see any examples of where duty of candour had been applied, staff demonstrated an understanding of their responsibilities and could describe the process and what they would do.

The service had not recorded any never events. During the 12 months prior to our inspection there had been 6 incidents reported.

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

From the incidents we reviewed we saw a thematic review had been completed and learning shared because of incidents, involving how messages might be perceived by a patient and shared learning from another hospital in the group following a broken probe cover resulting in the removal of all covers.

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

Is the service effective?

Inspected but not rated

We rated it as good.

Evidence-based care and treatment

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

Good

Diagnostic imaging

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Care, treatment and support was delivered in line with legislation, standards and evidence-based guidance, including the National Institute for Health and Care Excellence (NICE) and other expert professional bodies, to achieve effective outcomes.

The service used policies, care and treatment pathways, and clinical protocols and processes. Policies were available to all staff on the intranet system and staff demonstrated they knew how to access them.

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

There was a quality assurance schedule. All staff were aware of the quality assurance procedures for all imaging equipment. We saw documentation was recorded and completed each month.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. A water cooler was available for patients to use and drinks and snacks were available in the nearby café on the ground floor of the hospital.

Pain relief

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

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

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

No pain-relieving medicines were used within the service.

Patient outcomes

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

The service participated in relevant national clinical audits. The service regularly reviewed the effectiveness of care and treatment through local and national audit with a structured audit programme. This enabled the service to benchmark the standard of care provided against local and national standards.

These audits included diagnostic reference levels; radiation protection; reject analysis to identify any trends, such as the same radiographer or the same examination; diagnostic clinical practice review and documentation; diagnostics clinical evaluation of auto reported studies; ultrasound peer review, ultrasound guided injections (USGI) documentation and DVT ultrasound. Radiologists from a local NHS trust audited the consultant radiologist. There was a peer review audit tool and sonographers across the group audited each other's reports.

Good

Diagnostic imaging

Outcomes for patients were positive, consistent and met expectations, such as national standards.

Managers used information from the audits to improve care and treatment. Action plans were developed to address areas of improvement and were regularly reviewed and reported monthly to the governance meeting. There were action plans for equipment services and calibration, the X-ray room, portable equipment, the MRI, and ultrasound.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service made sure staff were competent for their roles.

One radiographer gave contrast injections. However, this happened rarely, around once every 3 months. To maintain competency there was potential for cannulations to be done in the outpatient department.

There was no specific training on the effects of static magnetic field as outlined under the Control of Electro Magnetic Fields at Work Regulations. Staff had limited knowledge of the effects apart from it could cause dizziness.

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

Staff were given a full induction tailored to their role before they started work. Staff confirmed they received a comprehensive induction, felt confident, and prepared to work in the department. An induction checklist was completed for all new staff with a competency assessment of clinical and theoretical skills.

Managers supported most staff to develop through yearly, constructive appraisals of their work.

The service was 80% compliant with the annual appraisals for staff. There were 2 outstanding appraisals. The manager had been in post for 5 weeks and explained the department had been without a permanent manager for the last 3 months and completion of appraisals had slipped as a result. The manager was focused on achieving full compliance as soon as was possible.

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

There were referral guidelines and service protocols for ultrasound, MRI and X-rays.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. There was a commitment to training and education within the department. Staff told us they were encouraged and supported with training and there was good teamwork.

Staff were encouraged to keep up to date with their continuing professional development and maintain their existing skills. There were opportunities to attend external training and development in specific areas.

Good

Diagnostic imaging

The service ensured relevant staff continued to maintain registration with relevant bodies. The service held records to show the professional registration for the clinicians was checked annually with the professional body. For example, radiographers were registered with the Health and Care Professions Council.

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

Multidisciplinary working

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

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

Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. Staff contacted wards and other health care professionals to discuss any specific health care needs in preparation for the X-ray or scan.

The team worked closely with the outpatient and theatre teams. A project with theatre staff had been looking at the weight of lead aprons and the team was looking at lighter samples to try.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. There were multidisciplinary integrated clinical pathways to improve the patient outcomes. Staff attended the weekly scheduling meeting to review the last week's theatre lists and the weeks ahead. Discussions included equipment ordered, any adjustments, for example for patients with a learning disability, the bed capacity, clinical requirements and support for the ward, any alerts, for example allergies, and staffing. Any gaps were identified and actions taken to address them.

Staff worked closely with the Ionising Radiation (Medical Exposures) Regulations (IR(ME)R) practitioner licence holder and other designated reporters.

A twice-yearly radiation protection committee meeting was held where the medical physics expert attended. The purpose of the meetings was to identify various topics for discussion including emergency contingency plans, any reported radiation incidents and review of the monthly radiation scenario training provided to staff. We saw minutes of these meetings, which showed they were consistently attended.

Seven-day services

Key services were available to support timely patient care.

The service provided services on Monday to Friday with additional clinics running on some weekends. When demand fluctuated, additional Saturday lists were arranged or working days would be extended to accommodate extra scans or X-rays.

Health Promotion

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

Good

Diagnostic imaging

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

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

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

There was a policy setting out the requirements for presuming or assessing mental capacity; documenting assessment outcomes and recording the rationale behind any decision taken on behalf of the person lacking capacity.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. They could describe and knew how to access the policy and get accurate advice in these areas. Staff said they were confident in making capacity assessments.

Following our inspection, we were provided with training data that confirmed all staff were compliant with combined Mental Capacity Act and Deprivation of Liberty Safeguards training.

Staff understood how and when to assess whether a patient had the mental capacity to make decisions about their care. If staff felt a patient lacked the capacity to consent to the procedure, they would seek further advice.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records.

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

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

Is the service caring?

Good

We rated it as good.

Compassionate care

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

Good

Diagnostic imaging

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Care was delivered with kindness and patience. The atmosphere was calm and professional and staff were focused on the needs of the patients.

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

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. They were knowledgeable about the framework to support communication with families who were non-English speakers, or for whom English was a second language. Support was also available for patients with hearing or visual impairment, or who had learning disabilities. Where possible, staff provided longer appointment slots to patients who needed them. Staff made sure necessary equipment was available to help patients with mobility difficulties.

Patients said staff treated them well and with kindness. We saw staff spoke to patients in a friendly and considerate manner and gave a high standard of care. Patients were offered a chaperone if requested. All patients were unanimously positive about the care they received. They spoke positively about their experience in the department. They confirmed all staff were kind and helpful to them. One patient said staff “put me at ease when I felt very anxious.”

Emotional support

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

Staff gave patients help, emotional support and advice when they needed it. All patients said staff had been helpful and supportive. We observed staff providing emotional support to patients during their visit to the department. Patients’ individual concerns were promptly identified and responded to in a positive and reassuring way.

Staff supported anxious patients by arranging for them to see the scanner before their appointment date.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Throughout our inspection, we saw patients being treated with dignity and respect. Voices were lowered to avoid confidential or private information being overheard. All patients said their privacy and dignity was maintained.

Staff explained that sometimes patients did not know if they were claustrophobic, so if a patient could not tolerate their scan, staff worked with them to either re-attempt the scan or to rebook and directed the patient to obtain mild sedation from their GP.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Patients were spoken with in an unhurried manner and staff checked if information was understood.

Good

Diagnostic imaging

Understanding and involvement of patients and those close to them

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

Staff made sure patients understood their care and treatment. Patients were involved with their care and decisions taken. Patients said all procedures had been explained clearly and they felt included in the plans and were well informed.

Staff talked with patients in a way they could understand, using communication aids where necessary. Patients told us they were provided with a wide range of documentation to explain their treatment and we saw staff gained their consent and explained each procedure. We observed staff explaining things to patients in a way they could understand. One patient said, “the information sent to me had helped me prepare for my appointment.”

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

Feedback was captured on a tablet. However, response rates were low, and the manager was looking at ways to improve the response rate. We reviewed feedback from May 2022 which showed 95% of patients were either satisfied or very satisfied with their experience.

Is the service responsive?

Good

We rated it as good.

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the needs of the local population.

Facilities and premises were appropriate for the diagnostic services being delivered. Facilities and premises were appropriate for the X-ray and scanning services being delivered. The environment was appropriate, and patient centred. The waiting area was located outside of the main radiology department and seating was available for the number of patients and relatives attending the department. Patients could not be observed from the main reception office There were plans to install a window from the reception office to enable staff to see the patients waiting.

Staff monitored and took action to minimise missed appointments. Patients were telephoned to remind them about their appointments. Staff ensured that patients who did not attend appointments were contacted.

There were plans to increase capacity by providing MRI scans on 5 days each week and to develop a computed tomography (CT) service. The manager was working with the business planning manager to develop business cases for consideration.

Good

Diagnostic imaging

Managers monitored and took action to minimise missed appointments. Information about the unit and the procedures were provided with the appointment details. Staff were also available by telephone to discuss any concerns.

Meeting people's individual needs

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

The service had systems to help care for patients in need of additional support. For those patients coming from the inpatient wards, timing was considered to support their other medical needs. For example, patients' medicines and treatments were considered and appointments fitted around the needs of the patient.

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

The service managed care of vulnerable service users by allowing a double appointment, where possible, for patients living with dementia or learning disabilities.

There were reasonable adjustments made so that people with a disability could use services on an equal basis to others. The access to the unit and use of equipment met the needs of patients and visitors with a disability.

There was car parking, including disabled parking, available nearby on the hospital site. However, some patients we spoke to had struggled to find a free space and had parked in the nearby residential road.

The service had information leaflets available in languages spoken by the patients and local community. This ensured patients had access to written information about their procedures. Patient information was in the process of being updated and translated into 3 languages used locally.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Support was available for communication with patients for whom English was a second language, people with hearing or visual impairment, or who had learning disabilities. Information could also be provided in large print, in braille, or a British Sign Language interpreter was available. Staff could access translation services for patients through a language system.

A hearing loop was available at reception and was portable and could be moved around the hospital.

The hospital had recently purchased a specialist translation electronic device with instant access to over 200 interpreters who were available by phone and video call. British Sign Language was available by video link.

Access and flow

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

Good

Diagnostic imaging

Managers and staff planned that patients did not stay longer than they needed to. When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Managers worked to keep the number of cancelled appointments to a minimum. During the last 12 months 424 appointments had been cancelled or rescheduled. Many of the reasons recorded were outside of the service's control.

The service managed 'did not attend' rates. When patients did not attend a pre-booked scan or X-ray staff attempted to telephone the patient to establish the reason for the absence and make sure the scan or X-ray was rebooked. Should further contact not be successful or up to 3 appointments were not attended, the administrative staff contacted the referrer and discussed the next course of action.

Staff monitored waiting times and were taking actions to improve patients' access to services within agreed timeframes and national targets. Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Waiting times were currently 2 weeks for MRIs, 1-2 weeks for ultrasound and up to 6 weeks for ultrasound guided injections. X-rays were flexible with walk-in appointments available.

We spoke with patients who said they were satisfied with the speed of appointments and waiting times were kept to a minimum and they were always informed if the clinics were running late.

Patients were kept informed of any delays once they arrived in the department. We saw appointments were running up to 40 minutes late and patients were invited to get a free coffee from the café.

During the period from April 2022 to March 2023 there were 10,416 NHS funded attendances and 907 self-pay attendances.

The department was open from Monday to Friday with MRI scans available on Tuesdays to Fridays from 8am to 8pm. There were appointments for additional X-rays on Saturdays with evening appointments on Tuesdays for X-rays and ultrasound.

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

Learning from complaints and concerns

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

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

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

Good

Diagnostic imaging

Staff understood the policy on complaints and knew how to manage them. There were policies and processes to appropriately investigate, monitor and evaluate patient's complaints. For further details about the complaints process please refer to the learning from complaints and concerns section of the surgery report.

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

We saw 2 complaints about the diagnostic service during the period from November 2021 to October 2022. They related to incorrect reporting.

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

Is the service well-led?

Good

We rated it as good.

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

Leadership

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

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

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

The team were knowledgeable and enthusiastic about the service and actively worked to improve delivery of care.

Staff told us leaders were visible and approachable and we heard about support for members of staff in the department. They felt able to openly discuss issues and concerns with their immediate manager. They believed they would be listened to, and actions taken when necessary if anything needed to change or be addressed.

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

Good

Diagnostic imaging

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

Vision and Strategy

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

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

There were secondary care group, local and team objectives. The diagnostic team objectives were divided into 3 parts: people, performance and growth.

The people part related to the recruitment of a radiology manager, who was now in post, stabilising the team, developing staff learning and recognising achievements.

The performance part related to achieving 100% compliance with mandatory training, up to date competencies, clinical supervision, audit, increasing the friends and family response rate, improving the computed tomography (CT) service sub-contracted to a local NHS hospital and to look at alternative options.

The growth part related to increasing the number of ultrasound guided injection lists to reduce the waiting list, adding a small GP list on Saturdays to improve throughput in X-ray, increasing the number of MRI scans, increasing the number of CT scans to bring them in house, and increasing relationships with the ward to ensure efficient working.

Services had been planned to meet the needs of the relevant population. Progress against delivery of the strategy was monitored and reviewed.

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.

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

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

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

Staff said there was a strong emphasis on their safety and well-being. Equality and diversity were promoted within the hospital and wider group. Staff, including those with protected characteristics under the Equality Act, felt they were treated equitably.

The staff we spoke with during inspection were open and friendly and spoke positively about working at the hospital. They felt supported, respected, valued and proud to work for the organisation. Radiographers said they felt valued by clinical colleagues in the hospital. For example, when discussing the timeliness of X-rays, they felt able to challenge decisions and were confident their views would be considered.

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

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

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

Governance

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

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. There was a clear performance management reporting structure with regular governance meetings looking at operational performance. There were department meetings, heads of department meetings, and quality and governance meetings. Issues discussed at the meetings included a review of incidents reported, complaints, audit, infection control, risks identified on the risk register and risk management. The meetings were minuted and the actions required were monitored with details of the person responsible for those actions and a review date.

In addition, radiology managers across the group met quarterly to discuss performance and themes. From the minutes of the meetings, we saw a review of incidents, the risk register, governance, learning and objectives. Feedback from the working groups were discussed and policies were updated.

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

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

Staff were clear on who their radiation protection advisor and medical physics expert were and could describe how to contact them.

Good

Diagnostic imaging

Staff were recruited in line with national guidance and the recruitment process ensured staff were competent, capable and confident in their area of practice. Further details about the recruitment process can be found in the governance section of the surgery report.

Management of risk, issues and performance

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

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

There were processes to manage current and future performance which were reviewed and improved through a programme of clinical and internal audit. The service took part in an audit programme and evidence of improvements or trends were monitored. Performance data and quality management information was collated and examined to look for trends, identify areas of good practice, or question any poor results.

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

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. The service had a risk register which clearly identified individual risks and the action taken to mitigate the risks. The position was monitored at monthly meetings. There was alignment between recorded risks and what staff said was 'on their worry list'. These included: lone working, leakage of toxic substances, loss of service and MRI acoustic noise.

There was an adverse incident information recovery plan in the event of equipment breakdown and a new business continuity plan contained a business impact assessment form for completion.

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

Information Management

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

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

Staff had access to information they required to provide good patient care. Staff used electronic systems to manage patient information and to gain access to information.

All staff had access to the intranet, which contained the information and guidance for staff to perform their duties. Staff we spoke with were familiar with the intranet and knew where to find the information they needed.

Good

Diagnostic imaging

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

The service had an established electronic information and patient record system. All staff had access to the system and to up-to-date, accurate and comprehensive information on patient's care and treatment.

The service had a range of policies including information security and procedures relating to radioactive materials and licences. The confidentiality of electronic patient information was maintained, and staff had access to the general data protection regulation policy.

Engagement

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

People's views and experiences were gathered and acted on to shape and improve the services and culture. Patients were encouraged to report on their experience by completing the friends and family test on an electronic tablet following their procedure. From May to October 2022, data showed a 99% to 100% satisfaction rate with all patients experiencing a good service.

Responses were shared with all staff in departments. Staff received this as positive feedback but also took on board any negative comments that helped to improve the service. Feedback was used to evaluate the service and the feedback we reviewed was unanimously positive.

Staff were also actively engaged, including those with a protected characteristic, so their views were reflected in the planning and delivery of services and in shaping the culture. Staff told us they felt engaged, informed and up to date with what was happening within the department and the wider hospital. Information was shared through different forums. These included emails and staff meetings. Staff meetings were held each month. Staff told us a variety of things were discussed including serious incidents and key messages from the senior management team.

To increase awareness of quality and patient safety issues among all staff, the senior management team (SMT) conducted regular walkabouts across the hospital. Information and concerns were summarised and taken to SMT meetings for consideration and resolution. Staff said they appreciated the walkabouts and were encouraged to speak up and voice their suggestions and solutions.

Staff had access to health and wellbeing services through an employee assistance programme. There was a well-being champion and staff had access to a well-being App.

Staff received a number of benefits including, bonuses in February, an eye test scheme, health insurance, cycle to work scheme, discount at the hospital canteen, 2 free lunch passes per month, chocolate gifts at Easter and Christmas. This year it had been agreed by staff and managers that, in view of the current cost of living challenges, money for Easter eggs would be donated to a charity instead.

Good

Diagnostic imaging

Learning, continuous improvement and innovation

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

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

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

There were systems to support improvement and innovation work, data systems, and processes for evaluating and sharing the results of improvement work. The team was working towards a quality standard for imaging accreditation to standardise and develop services.

There had been investment in new ultrasound equipment and the refurbishment of the MRI and X-ray areas.

There was also investment in the development of the next generation of radiographers through an apprenticeship, post-graduate funding and upskilling in MRI reporting.

There was planned continuous development of the department by exploring opportunities to increase the capacity for MRI and to develop a computed tomography (CT) scanning service to improve the service and patient experience and to provide opportunities for staff development.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance Not all staff were compliant with mandatory training and there was not oversight of the quality of data and systems used to monitor mandatory training compliance. Not all risks were recorded effectively and monitored.