Spire Hull & East Riding Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from 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?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

Summary of findings

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

Spire Hull and East Riding Hospital is operated by Spire Healthcare Limited. The hospital has 43 beds. Facilities include a ward, four operating theatres, X-ray, outpatient and diagnostic facilities.

The hospital provides surgery, medical care, diagnostics, services for children and young people, and outpatients services. We inspected surgery, medical care, diagnostics, services for children and young people, and outpatient's services.

We inspected this service using our comprehensive inspection methodology. The inspection was unannounced (staff did not know we were coming) and took place from 18 to 20 September 2018.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

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

Services we rate

Our rating of this hospital/service improved. We rated it as good overall.

- Staffing was managed safely across all services. We found there were enough staff with the appropriate skills, experience and training to keep patients safe and to meet their care needs.The hospital was visibly clean and infection prevention and control processes had improved. Staff were aware of the duty of candour. Incidents were reported and the quality of root cause analysis (RCA) investigations was robust. Mandatory training compliance was above the hospitals trajectory including safeguarding of vulnerable adults and children. Staff we spoke with were aware of their responsibilities and of appropriate safeguarding pathways to use to protect vulnerable adults and children.
- Patients were cared for effectively using evidence based best practice guidance. Policies were mostly developed nationally. Staff across the services had received an up to date appraisal and had the right knowledge and skills to care for patients. Procedures for consent had improved. There were clinical indicators which were monitored and compared across the company through a clinical scorecard. The hospital participated in a number of in-house and national audits for surgical patients, such as the National Joint Registry (NJR) and patient reported outcome measures (PROMS). The daily safety huddle for all heads of departments was led by the hospital director and involved department leads from all areas. We saw effective multidisciplinary working between staff of all grades at the hospital.
- Patients were cared for in a kind, caring and compassionate way. Patients and relatives, we spoke with gave consistent feedback without exception. We observed positive interaction of staff with patients. We found that the services received positive feedback for the Friends and Family Test, however the response rate was low. Patient records showed that patients were involved in their care and their preferences were taken in to account.
- The services were planned and managed to meet demand. There was clear inclusion and exclusion criteria for accepting surgical patients. The hospital had introduced a 'one stop' assessment process for patients prior to surgery. In the twelve months from August 2017 to July 2018 referral to treatment (RTT) data showed that the provider had exceeded the target of 90% of admitted patients beginning treatment within 18 weeks every month and that 100% of patients had begun treatment within target. There was an average inpatient length of stay of 1.9 days. There was an active group of volunteers working within the hospital who supported patients through their patient journey. Open

visiting times were promoted and parents and carers were able to stay overnight with children where required. There was personalised, patient-centred care provided for patients living with a dementia and the hospital had dementia link nurses in place. Complaints were managed and overseen by the hospital director and clinical complaints specifically overseen by matron. The reduction of avoidable cancellations was a priority for the hospital and processes and systems within the pre-operative assessment team were under review. However, we noted that 83 surgical procedures had been cancelled for non-clinical reasons from August 2017 to July 2018, of these 71% were operated on within 28 days.

- The hospital had a clear management structure in place with clear lines of responsibility and accountability. Managers had right skills and abilities to run a service providing high-quality sustainable care. Staff of all grades told us their local leaders and the senior management team were extremely supportive, visible and approachable. Staff of all grades spoke positively about the culture within the hospital and told us they were passionate about their roles and the hospital. Professional relationships between all staff promoted the values of the hospital and staff said they felt valued and worked well together. The hospital had a robust clinical strategy action plan in place. Although, there is no requirement for independent healthcare hospitals to have a freedom to speak up guardian (F2SUG), the hospital had appointed a member of staff to this role. We found that governance processes had improved and were more robust. Minutes of the Medical Advisory Committee (MAC) meeting were detailed and included comprehensive governance information. Consultants working at the hospital were utilised under practising privileges (authority granted to a physician or dentist by a hospital governing board to provide patient care in the hospital); these, with appraisals, were reviewed every year by the senior management team.

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North Region)

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Not sufficient evidence to rate	Medical care services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We did not have enough robust and proportionate evidence to rate medical care due to the small nature of the service and the limited activity taking place at the time of our inspection.
Surgery	Good	Surgery was the main activity at the service. Where our findings also apply to other activities, we do not repeat the information but cross-refer to the surgery section of the report. We rated surgery as good overall because it was safe, effective, caring, responsive and well led. Since our last inspection the hospital had improved the services for surgical patients and strengthened the overall governance systems.
Services for children and young people	Good	We rated this service as good because it was safe, effective, caring, responsive and well-led. Since our last inspection the hospital had improved the services for children and young people including the environment and the governance and reporting systems to monitor outcomes.
Outpatients	Good	We rated this service as good because it was safe, caring, responsive and well led. We do not rate effective for outpatients. Since our last inspection the hospital had improved the outpatient facilities including opening a fully equipped physiotherapy department on the Lowfield's site.

Summary of findings

Diagnostic imaging

Good 

We rated this service as good because it was safe, caring, responsive and well led. We do not rate effective for diagnostic imaging.
Since our last inspection the diagnostic imaging service had improved services including moving from mobile units to an onsite purpose-built unit.

Summary of findings

Contents

Good

Spire Hull and East Riding Hospital

Services we looked at
Medical care, Surgery, Services for children and young people, Outpatients and Diagnostic imaging.

Summary of this inspection

Background to Spire Hull & East Riding Hospital

Spire Hull and East Riding Hospital is operated by Spire Healthcare Limited. The hospital opened in 1986. It is a private hospital situated in Anlaby, located in the west of Hull. Spire Hull and East Riding Hospital primarily serves the communities of the East Riding of Yorkshire and Hull. It also accepts patient referrals outside of this catchment area.

Facilities at the hospital site include a ward, an operating suite with four operating theatres all with laminar flow. The suite also offers an integral, accredited sterile services department and two recovery areas consisting of nine bays in total. Previously the hospital had a level two critical care facility. At the time of our inspection the hospital was not undertaking any level two care. The former critical unit had been reconfigured and was being used as an extended recovery unit.

In 2014, the company acquired Spire Hesslewood Clinic, which is located approximately one and a half miles south of Spire Hull and East Riding Hospital and is operated as a satellite to Spire Hull and East Riding. The clinic is under the same management structure. The two sites also have a combined data collection process and clinical dashboard, meaning that data is not available at a site level for Spire Hull and East Riding Hospital or Spire Hesslewood Clinic.

The two sites are registered separately with CQC.

The hospital provided outpatient and inpatient services for surgery, including cosmetic surgery and medical care including cardiology, endoscopy and oncology. Patients were cared for as NHS, insured and privately funded patients. Services were provided to children and adults of all ages for outpatients and three years old and above for inpatient care (children under three are treated in dermatology outpatient's clinics, however, no interventional treatment is given).

The service had 15 outpatient consulting rooms across two sites with a treatment room at each location and phlebotomy on the main site along with pathology services, an imaging department with MRI and CT, cardiac service.

There was also an outpatient physiotherapy department with five consulting rooms and a fully equipped gym on the Lowfield site at Spire Hull and East Riding Hospital. An ENT outreach clinic was provided at the Diadem clinic on a weekly basis.

The hospital's ward has 34 single rooms, all with en suite facilities, and a specifically designed suite which consists of three, four and five bedded bays offering single sex accommodation. There is a day case suite which has four bays.

There is also a restaurant providing food for patients, staff and visitors.

Surgical outpatients included; breast care, ear, nose and throat, cosmetic surgery, orthopaedic surgery, general surgery (including weight loss surgery) ophthalmology, audiology. Medical outpatient consultations were available for a wide range of conditions such as; heart conditions, dermatology, pain and migraine. A health and wellbeing service for men and women was also available.

The physiotherapy department offered a wide range of services, including assessment and treatment of patients attending the hospital for surgery, a variety of therapies including pain management and a sports injury service. Self-paying patients could also refer themselves for physiotherapy assessment and treatment. The physiotherapy department was open from 8:00 – 18:00 for outpatients. The department offered flexible appointments for outpatients outside of these times and at weekends if requested.

Diagnostic imaging at Spire Hull provided various services such as x-ray, ultrasound, Computerised Tomography (CT), Magnetic Reasoning Imaging (MRI), Fluoroscopy, Angiography and Mammography. The service was previously inspected in September 2015. Since the previous inspection the service had implemented a MRI and CT scanning unit in the department.

The hospital has been inspected five times, the most recent inspection took place in September 2015. Following that inspection, the hospital was rated requires improvement and we issued requirement notices to

Summary of this inspection

ensure compliance with regulations Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment, Regulation 15 HSCA Regulations 2014 Premises and equipment and Regulation 17 HSCA (RA) Regulations 2014 Good governance. The hospital provided an action plan, which was regularly reviewed by CQC, to provide us with assurance that the hospital had met the requirements.

We inspected this hospital as part of our independent hospital inspection programme. The inspection was conducted using the Care Quality Commission comprehensive inspection methodology. For this inspection, the team inspected the following five core services at Hull and East Riding hospital:

- Medical Care
- Surgery
- Diagnostic Imaging
- Children and young people
- Outpatients

The hospital had a registered manager, Chris Harrison, who had been in post for approximately three years.

Our inspection team

The team that inspected the service comprised a CQC lead inspector Kerri Davies and five other CQC inspectors. There were also four specialist advisors with expertise in governance, surgery, medicine, diagnostic imaging and children and young people's services. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Why we carried out this inspection

We inspected this hospital as part of our independent hospital inspection programme. There were no special reviews or investigations of the hospital ongoing, by the CQC, at any time during the 12 months before this inspection.

How we carried out this inspection

The inspection was unannounced and conducted using the Care Quality Commission comprehensive inspection methodology. During the inspection, we visited the ward, theatres, outpatients (including physiotherapy) and diagnostic departments. We observed the environments, checked equipment and looked at patient information. We spoke with more than 50 members of staff including; registered nurses, health care assistants, volunteers, catering and housekeeping staff, reception staff, medical staff, operating department practitioners, administrators, heads of departments and the senior leadership team. We spoke with 25 patients and five relatives of children. During our inspection, we reviewed 23 sets of patient records. We also reviewed performance information from, and about, the hospital.

Information about Spire Hull & East Riding Hospital

The hospital has one ward and is registered with CQC for 56 beds but we were told us 43 beds were in use at the time of our inspection. There are also x-ray, outpatient and diagnostic facilities.

The hospital is registered for the following regulatory activities:

- Surgical procedures.

Summary of this inspection

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

During the inspection, we visited the ward, theatres, outpatients (including physiotherapy) and diagnostic departments.

We observed the environments, checked equipment and looked at patient information.

We spoke with more than 50 members of staff including; registered nurses, health care assistants, volunteers, catering and housekeeping staff, reception staff, medical staff, operating department practitioners, administrators, heads of departments and the senior leadership team.

We spoke with 25 patients and five relatives of children. During our inspection, we reviewed 23 sets of patient records.

We also reviewed performance information from, and about, the hospital.

There were no special reviews or investigations of the hospital ongoing, by the CQC, at any time during the 12 months before this inspection.

Activity (August 2017 to July 2018)

- In the reporting period August 2017 to July 2018 there were 3321 inpatients and 10081day case episodes of care recorded at the Hospital; of these 85% were NHS-funded and 15% other funded.
- 60% of all NHS-funded patients and 40% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 38140 outpatient total attendances in the reporting period. Data given below includes the outpatient and physiotherapy services provided at Spire Hull and East Riding Hospital, Lowfield Clinic, the Diadem outreach clinic and Hesslewood Clinic unless otherwise stated.
- From August 2017 to July 2018, there were 38,140 outpatient and physiotherapy attendances, 830 (around 2%) of these were children's outpatient attendances; four appointments were for children aged 0 to two years, 607 were for three to 15 years and 219 were for 16 to 17 years.
- From August 2017 to July 2018, 85% of patients seen were NHS funded and 15% were private patients. During this period, 8,736 NHS and 2,046 private patients attended the hospital for first appointments and 23,496 NHS and 3,862 private appointments were follow-ups. New to follow up ratios were 1 to 2.7 for NHS funded patients and 1 to 1.9 for privately funded patients.
- 238 surgeons, anaesthetists, physicians and radiologists worked at the hospital under practising privileges. Two regular resident medical officer (RMO) worked on a 24-48-hour rota. The hospital employed 61 whole time equivalent (wte) registered nurses, 35.5 wte care assistants and ODPs and 167 wte other staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

There had been one never events in the period August 2017 to July 2018.

From July 2017 to June 2018 there had been 828 clinical incidents, the majority (705) were reported as no harm, 57 were low harm, 61 were moderate harm, one was severe harm. There had been four deaths reported by the hospital and 27 serious incidents requiring investigation.

The hospital had reported one incident of Methicillin-resistant Staphylococcus aureus (MRSA) in 2017. However, this was not attributed as being acquired at the hospital. The root cause analysis investigation was inconclusive because the patient had visited multiple healthcare providers. There had been no incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA), hospital acquired Clostridium difficile (C.diff) or hospital acquired Escherichia coli **(**E-Coli).

There had been 79 complaints from August 2017 to July 2018.

Services accredited by a national body:

- Société Générale de Surveillance(SGS) accreditation for Sterile Services Department.
- British United Provident Association (BUPA).
- United Kingdom Accreditation Service (UKAS).
- Macmillan (Level 5).

Services provided at the hospital under service level agreement:

- Clinical waste removal
- Cytotoxic drugs service
- Interpreting services

Summary of this inspection

- Laser service
- Laundry
- Maintenance of medical equipment
- Non-clinical waste removal
- Occupational health
- Pathology and histology
- Radiation protection
- RMO provision
- Staff agency
- Blood Transfusion

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- Mandatory training rates across all services exceeded compliance targets.
- The hospital had appropriate policies to support staff to safeguard adults and children and young people and all safeguarding incidents at the hospital were reported through the electronic incident reporting system.
- We found that all areas of the hospital were visibly clean and tidy. Infection prevention control processes had improved. The hospital had a director of infection prevention and control (DIPC) with an appropriate post graduate accredited qualification. There was an infection prevention & control (IPC) lead and an IPC committee responsible for ensuring that the hospital complied with effective IPC requirements.
- The hospital had improved the ward environment and waiting areas to make them more child-friendly.
- The hospital followed clear admission criteria to ensure they were able to provide safe care and treatment. This included a registered children's nurse with responsibility and accountability for the whole of the child's pathway.
- The diagnostic imaging department has implemented the world health organisation (WHO) safety checklist since the previous inspection.
- Results of World Health Organisation (WHO) surgical safety checklist 'five steps to safer surgery' audits showed 95% compliance for the surgical service.
- Staffing levels, across all services were planned to ensure there was sufficient numbers of appropriately trained staff to safely care for patients.
- Incident reporting processes and methods for shared learning were robust.

However, we also found the following issues that the service provider Needs to improve:

- Some safety checks and log books for equipment, for example the difficult-intubation equipment trolley were not completed appropriately.
- Prescription charts were not always completed in full.

Summary of this inspection

- Work to mitigate some environmental and security risks had not yet been fully completed, for example ligature risks and secure access in the children's ward area and the suitability of waiting areas for older children.

Are services effective?

Good

Are services effective?

We rated effective as good because:

- Care pathways were based on clinical guidelines from established and recognised bodies (for example National Institute for Health and Care Excellence).
- The hospital had introduced a separate clinical scorecard to monitor the effectiveness of care and treatment for children and young people.
- The hospital had a clinical audit programme and clear approach to policy management. The hospital completed national and local audits and discussed these at relevant governance meetings.
- Patients confirmed their dietary requirements were managed well and that they were given clear information about fasting prior to surgery.
- Pain scores were checked with patients and documented by staff and appropriate pain relief provided.
- The hospital used a range of tools to monitor and benchmark performance against targets, other hospitals and providers; data reported to the National Joint Registry showed 'as expected' patient reported outcomes for both hip and knee replacements.
- Local audits showed 100% of cancer patients had evidence of multi-disciplinary team discussion recorded within their notes.
- Records showed that staff had up to date appraisals and their registration had been validated. All staff caring for children and young people were required to have completed paediatric competencies and have up to date training in safeguarding level three and life support, appropriate to their role.
- The daily safety huddle for all heads of departments was led by the hospital director and involved department leads from all areas.
- We saw effective multidisciplinary working between staff of all grades at the hospital.
- The hospital had negotiated a health promotion commissioning for quality and innovation (CQUIN) with the local clinical commissioning group (CCG) to monitor smoking and alcohol consumption.

Summary of this inspection

- The hospital had signed up to the 'You're Welcome' accreditation scheme for services for children and young people.
- Staff demonstrated knowledge and understanding of the Mental Capacity Act and consent.

However, we also found the following issues that the service provider needs to improve:

- Action plans following audits were often documented as single actions without detailing any subsequent actions or cooperation by other departments or disciplines.

Are services caring?

Good

Are services caring?

We rated caring as good because:

- The hospital was proactive in seeking patients' views and their experience of care and treatment and they were given time to ask questions and to make sure they understood what was to happen.
- 'Friends and Family test' (FFT) audits of patient feedback showed 98% of patients would recommend the hospital to a friend or relative.
- Staff were passionate about providing the best possible service and experience for their patients. During the inspection we observed patients were treated with care, compassion, and respect by all staff, greeted professionally on their entrance to the hospital and directed to the relevant service.
- The hospitals lead nurse for children and young people demonstrated compassionate leadership and a clear understanding of the emotional needs of vulnerable young people and their families.
- Staff took practical steps to minimise anxiety of children and young people and prepare them for procedures, parents/carers could stay overnight where required, children (and parents) were able to wear their own clothes in theatre.
- Patient led assessments of the care environment (PLACE) showed that privacy, dignity and well-being was scored at 85%.
- There was an established volunteer programme in place.
- Patients told us treatment had been explained and their questions were answered fully by both nursing and consultant staff. Patients also said, 'it was a really good experience using services at the hospital and that all staff were always polite and helpful.'

However, we also found the following issues that the service provider needs to improve:

Summary of this inspection

- The FFT response rates at the hospital were low and we did not hear of any plans to address and improve this.

Are services responsive?

Good

We rated responsive as good because:

- Service planning was responsive to the needs of local people and supported delivery of services offered by local NHS trusts. There was a wide range of services offered and they were available to NHS, self-funding and insured patients.
- The service was planned to ensure a qualified children's nurse was able to support children and young people from booking to discharge.
- Patients were referred to the surgeon of their choice where possible and seen by that consultant throughout their treatment ensuring continuity.
- The staff worked hard to meet people's individual needs and to improve access and flow. The hospital had introduced a 'one stop' assessment process for patients prior to surgery.
- Staff could access interpreters and translation services when necessary.
- Open visiting times were promoted, and parents and carers were able to stay overnight with children where required.
- There was personalised, patient-centred care provided for patients living with a dementia and the hospital had dementia link nurses in place.
- The hospital had reconfigured regular outpatient clinics to better meet the needs of children with learning difficulties and changed outpatient waiting areas to make them more child-friendly and cancellations were rare.
- We saw 'You said, we did' displays throughout the hospital which demonstrated learning from feedback and complaints and the changes made in response.
- There was an average inpatient length of stay of 1.9 days.
- The reduction of avoidable cancellations was a priority for the hospital and processes and systems within the pre-operative assessment team were under review.
- The service took complaints seriously and responded in a timely manner. There were examples where improvements had been made because of complaints. Complaints were managed and overseen by the hospital director and clinical complaints specifically overseen by matron.

However, we also found the following issues that the service provider needs to improve:

- There were still high numbers of adult patients affected by cancelled and rearranged clinics.

Summary of this inspection

- The hospital consent policy was unclear as it stated that it is not appropriate to use children under the age of 16 years and preferably not under 18 years to interpret for family members who do not speak English. Family members should not be used as interpreters for any clinical matter. In addition, the policy did not include local arrangements for accessing interpreters including for British sign language (BSL). However, we saw information about translation services displayed and this clearly stated family members should not be used. The senior team told us that the concern about the policy would be raised with the corporate team as this was a national policy.
- Staff recognised that information could not readily be made available in different languages or formats if required.

Are services well-led?

Good

We rated well-led as good because:

- The hospital had a clear management structure in place with clear lines of responsibility and accountability.
- The services had managers with the right skills and abilities to run a service providing high-quality sustainable care.
- Staff spoke highly of their immediate line managers and the hospital leadership team and felt they were listened to and engaged in the organisation. Staff of all grades told us the senior management team were extremely supportive, visible and approachable.
- Staff of all grades spoke positively about the culture within the hospital and told us they were passionate about their roles and the hospital.
- Professional relationships between all staff promoted the values of the hospital and staff said they felt valued and worked well together;
- The hospital had a robust clinical strategy action plan in place.
- Although, there is no requirement for independent healthcare hospitals to have a freedom to speak up guardian (F2SUG), the hospital had appointed a member of staff to this role.
- We found that governance processes had improved and were more robust. The governance of the children's and young people's service was now clearly defined and linked to the governance processes for the whole hospital. A children and young peoples (CYP) clinical score card system had been introduced to support structured monitoring of quality, performance and patient outcomes.
- The service took patient feedback seriously and had a desire to learn and improve.

Summary of this inspection

- Staff had been involved in developing a vision for their own areas of work.
- Minutes of the MAC meeting were detailed and included comprehensive governance information.

However, we also found the following issues that the service provider needs to improve:

- The hospital acknowledged that there was limited evidence that actions to mitigate risks, following serious incidents, were completed effectively.
- The minutes of clinical governance did not show evidence of analysis, challenge or assurance.
- The risk registers needed further improvement to ensure there are no long-standing risks and that all risks have evidence of actions to mitigate the risk.
- It was unclear whether the CYP service was sufficiently represented at senior level to influence and support strategic developments across the hospital involving children and young people.
- While arrangements were in place, the formal agreement for the transfer of sick children to the NHS was out of date.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Surgery	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
Outpatients	Good	N/A	Good	Good	Good	Good
Diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Not sufficient evidence to rate

Medical care

Safe	Not sufficient evidence to rate
Effective	Not sufficient evidence to rate
Caring	Not sufficient evidence to rate
Responsive	Not sufficient evidence to rate
Well-led	Not sufficient evidence to rate

Information about the service

Medical care services were a small proportion of hospital activity. These included endoscopy, cardiology and oncology. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.

Summary of findings

Due to the small nature of the service provided and the limited activity at the time of our inspection we did not have sufficient robust and proportionate evidence to rate medical care at the hospital.

However, we saw how the service was working to meet the needs of patients with dementia and that staff were committed to delivering person centred care. This work had been recognised with a national award. Oncology patients received individualised care with the support of an established multidisciplinary team and this was recognised through achievement of Macmillan accreditation.

Not sufficient evidence to rate

Medical care

Are medical care services safe?

Not sufficient evidence to rate

Mandatory training

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

Safeguarding

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

Cleanliness, infection control and hygiene

- For our main findings please refer to the surgery report.
- All clinical areas, providing medical care, that were in use appeared to be clean and tidy.
- Some areas of the hospital were undergoing or about to undergo refurbishment at the time of inspection. For medical services, this included the ward.
- Decontamination of flexible endoscopes occurred in the endoscopy department. The disinfection process was explained, and we were told that this was in accordance with Health Technical Memorandum (HTM) 01-06 guidance.
- Water safety sampling was completed monthly by an external contractor. The results were received and checked by the infection prevention and control lead nurse. We were assured that there was a formal process in place to protect patient safety in the event of water bacterial counts exceeding safe parameters.
- Information provided by the hospital informed us there was a water safety group which met quarterly.
- There was evidence that the oncology service undertook periodic audit of service delivery including hand hygiene observation, clinical practice asepsis, sharps management and disposal and waste management.
- We saw individual equipment, fixtures and fittings were labelled with a green sticker to indicate the date they were cleaned. However, we did see some signature gaps on the cleaning records and the records did not always indicate when departments were not in use or closed.

Environment & equipment

- For our main findings please refer to the surgery report.
- All clinical and patient areas providing medical care were welcoming, fit for purpose and free of clutter.
- We saw that the service was well equipped to care for patients safely and all equipment that was not being used was serviced, clean and stored appropriately. For example, the patient hoist on the ward was labelled as tested in accordance with LOLER (1998) regulations.
- We looked at portable electrical appliances and noted they had undergone testing for electrical safety within an appropriate timeframe and were labelled with the date a test was next due.
- There was a service contract with the manufacturer for maintenance of the endoscope washer-disinfector. In the event of machine failure, breakage of endoscopes or unsafe water bacterial counts, the safety contingency procedure was to cancel patients.
- There were appropriate spillage kits available in the department and the contents were within expiry dates. There were full instructions as supplied by the manufacturer kept with the kits.
- Training records of staff that operated the washer-disinfector were kept in the department and we were assured that all staff that use the machine were trained appropriately.
- Endoscope tracking processes were audited and indicated good compliance.
- The cardiac catheterisation room was clean and tidy. However, we noted an anaesthetic machine identified as 'theatre four' which we were told was out of use, in the cardiac catheterisation room. This was not labelled as being out of use and had a checking log with gaps and also old checking records in a drawer. It was not possible to identify if the logs related to this machine.
- The department was also unable to evidence a robust stock management system because some consumables were not stored in their original packaging and items with different lot numbers and expiry dates were mixed. This was noted by the manager at the time.

Assessing and responding to risk

- For our main findings please refer to the surgery report.
- In the ten sets of care records we reviewed we saw that patients were risk assessed and concerns were escalated appropriately. For example, staff had completed a National Early Warning Score (NEWS) tool, moving and handling assessment, pressure ulcer risk score, falls risk assessment, nutrition and hydration assessment, pain scores and venous thromboembolism risk assessment.

Not sufficient evidence to rate

Medical care

- Exclusion criteria for medical emergency admissions were stated in the emergency admissions policy (reference hospital policy 75). Staff explained that urgent or unplanned medical admissions that were not excluded, were risk assessed individually by a multidisciplinary team prior to being accepted for admission. This was noted to be in accordance with the service clinical admission and discharge policy (reference clinical 07).
- We were told by the manager that the cardiac catheterisation department only carried out low to medium risk procedures. All patients for admission were pre-assessed by a nurse prior to gaining consent to treatment.
- Staff we asked were aware of the service clinical admission and discharge policy (reference clinical policy 07) and could describe the procedure to be followed if an urgent transfer out was required.
- The hospital did not admit patients with complex medical conditions and patients were risk assessed for their suitability to be admitted, on an individual basis.
- In the event of suspected neutropenic sepsis, oncology patients were admitted to the NHS trust acute oncology service, under the terms of a service level agreement.

Nurse staffing

- For our main findings please refer to the surgery report.
- The service provided chemotherapy services two and a half days per week and had suitable numbers of qualified oncology nursing staff to provide a safe service.
- There were three qualified specialist oncology nurses employed. Additionally, there were a further two supernumerary registered nurses employed by the hospital, working under the terms of an honorary contract with the local NHS trust hospital whilst they were completing university accredited post graduate education in oncology nursing.
- Staff from the theatre staffing establishment covered the endoscopy staffing.

Medical staffing

- For our main findings please refer to the surgery report.
- There were no medical in-patients using the service at the time of inspection. We were told by a manager that all admitted medical patients were reviewed by their consultant at least once every twenty-four hours, seven days a week. We saw evidence of this in the care records we looked at.
- Consultants had to arrange cross-cover when required for their patients from suitably trained colleagues, with practising privileges. Consultant contact details for emergency contacts were located in the ward office and staff we spoke to were aware how to access this document.
- Information provided by the hospital informed us that medical treatment and procedures were carried out by medical staff who were mainly employed by other organisations (usually the NHS) in substantive posts and had practising privileges (the right to practice in hospital).
- The resident medical officer (RMO) was based in the hospital 24 hours a day.

Records

- Please refer to the Surgery report for findings in relation to governance and management of records systems in place.
- Medical records audit data for January to March 2018 and April to June 2018 were reviewed and indicated high compliance scores for all criteria. However, during inspection we reviewed 10 patient healthcare records and saw that there were some inconsistencies in the quality of record keeping. For example, some records made by medical staff were not always dated, timed and signed.

Medicines

- For our main findings please refer to the surgery report.
- Chemotherapy was prescribed using an electronic e-prescribing system, which held all the information required, such as patient blood results. Prescriptions were initiated by the oncology nurses, then checked and approved by the oncology consultant prior to dispensing.
- All chemotherapy was prepared off-site by an external provider.
- In the event of electronic system failure, staff advised us that the contingency plan was to revert to using a paper prescribing system.

Incidents

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

Not sufficient evidence to rate

Medical care

- There were no serious incidents reported in respect of medical services.

Safety Thermometer

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

Are medical care services effective?

Not sufficient evidence to rate

Evidence-based care and treatment

- For our main findings please refer to the surgery report.
- At our inspection in 2015, we were informed that the hospital was working towards JAG (Joint Advisory Group on endoscopy) accreditation and had completed a gap analysis to assist with this. We were advised that new reporting equipment was due to be introduced in December 2015 and this would enable them to evidence compliance with more of the criteria needed to achieve the accreditation, especially in relation to patient experience and comfort scores.
- At our inspection in 2018, staff told us that the service was still working toward JAG accreditation and advised this was not yet achievable due to inability to meet JAG environment and patient flow criteria.
- We saw written protocols in the oncology department, which the oncology nurses followed should complications such as extravasation of chemotherapy occur.

Nutrition and hydration

- For our main findings please refer to the surgery report.
- In the records we reviewed we saw that nutrition and hydration risk assessments were completed. Food and fluid record charts were implemented.
- We attended a ward 'huddle' which was attended by representatives from all departments, including oncology nurses, catering and pantry staff. At the huddle patients' special dietary needs were communicated clearly. This included alerting the staff to allergies and intolerances to foods and provision of diets which complied with religious beliefs.
- Dietary needs were recorded on a board in the ward pantry by room number, to protect patient privacy.
- Staff told us there was access to a dietitian as required for medical patients. This was formalised in a service level agreement with the NHS trust hospital.

Pain relief

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

Patient outcomes

- The endoscopy department had completed a tracking audit, of a randomly selected endoscope and the last 10 patients it was used for. The audit showed 100% compliance with the tracking process.

Competent staff

- For our main findings please refer to the surgery report.
- We were assured that staff within the medical service were competent and appropriately trained. For example, we saw the specialist oncology nurses' certification, held in the department.
- The oncology nurses told us they had protected time for continuous professional development (CPD) and we saw evidence in team meeting minutes that learning, and oncology updates were cascaded routinely to the rest of the team.
- The oncology service had already achieved Macmillan accreditation, and this was due to be reviewed in 2019.

Multidisciplinary working

- For our main findings please refer to the surgery report.
- There was an established process for multi-disciplinary team discussion of all cancer and cardiology patients prior to commencement of treatment.
- We were told that the medical oncology multidisciplinary team met regularly. The oncology nurses did not attend these meetings however, the information required was communicated in advance of patient admission for treatment via the consultant secretaries' notes and patient healthcare records.
- Oncology patients had access to psychological support services, dietetic services and site-specific cancer nurse specialists. They were also signposted to additional tailored support services such as a wig supplier and the 'look good feel good' service where this would be of benefit. There was a monthly support group meeting for breast cancer patients.
- Staff told us that a dedicated chemotherapy pharmacist worked closely with the oncology team. The oncology nurses and pharmacist attended a weekly meeting to discuss named oncology patients and their medication requirements.

Health promotion

Not sufficient evidence to rate

Medical care

- For our main findings please refer to the surgery report.
- The oncology nurses were qualified to educate oncology patients regarding health and wellbeing. They provided written, individualised patient 'chemotherapy packs', which included advice about reducing the risk of infection, maintaining healthy diet and smoking cessation. Written leaflets produced by Macmillan were also available in the department.

Consent, mental capacity act and DOLs

- For our main findings please refer to the surgery report.
- Staff explained how oncology patients were enabled to give their informed consent to treatment. We were told that prior to gaining a patient's written consent to chemotherapy, the oncology nurses liaised with the patient's oncologist and reviewed the information from the multidisciplinary team meeting.

Are medical care services caring?

Not sufficient evidence to rate

Compassionate care

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

Emotional support

- For our main findings please refer to the surgery report.
- Oncology patients had access to psychological support services when they needed them.

Understanding and involvement of patients and those close to them

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

Are medical care services responsive?

Not sufficient evidence to rate

Service delivery to meet the needs of local people

- For our main findings please refer to the surgery report.
- Medical services were planned to meet the needs of the local population. For example, patients requiring chemotherapy attended planned sessions on specific days of the week.

Meeting people's individual needs

- For our main findings please refer to the surgery report
- We saw evidence that the medical service was meeting individual patient needs.
- Oncology patients who had received chemotherapy were provided with written, clear information explaining what to do if they became unwell between visits.
- Oncology patients could contact the oncology nursing staff by telephone for advice within working hours and out of hours, they were automatically transferred to the local NHS hospital trust acute oncology service.
- We saw an example of an individualised chemotherapy information pack provided to patients; this contained a chemotherapy record book, information relating to signs and symptoms to look out for during chemotherapy, advice about symptom control, access to support services and contact details of the team should they require advice or urgent help.
- The service had a named specialist dementia lead nurse who explained how the patient journey is aligned with 'dementia champions' in every area of the service.
- The dementia lead nurse was accredited to teach a nationally recognised dementia care education programme. They had established a network of 300 'dementia friends', which included staff, patients and their carers. The dementia care training modules became established within the mandatory staff training programme in 2014.
- Staff showed us how person-centred care was planned for patients with dementia. For example, prior to admission, carers and patients were encouraged to complete a 'this is me' folder, which helped define any special patient needs, their likes and dislikes. Patients were provided with a 'twiddle muff' for sensory stimulation and occupation. We saw dementia-friendly signage on doors to the lavatories in the waiting area. There were leaflets signposting patients and carers to support services and we noted a 'carers are welcome' poster, which invited carers to come in to the service 24 hours a day.
- The service was awarded 'Spire Exemplar Site 2018' for its innovative approach to caring for patients with dementia and was recognised in the national press.
- We saw that the service had enrolled in the 'safe place scheme' and the logo was displayed at the hospital entrance. This initiative meant that vulnerable people could identify the facility as a 'safe place' and be assured they would receive appropriate help.

Not sufficient evidence to rate

Medical care

- Patients were then invited to attend a pre-chemotherapy session; this was a question and answer session and information was provided according to individual need and how much the patient wanted to know. The possible side effects of treatment were discussed together with the treatment plan. Patients were asked to invite someone to support them at the meeting if they wished.

Access and flow

- For our main findings please refer to the surgery report

Learning from complaints and concerns

- For our main findings please refer to the surgery report
- There were no complaints related to medical patients.

Are medical care services well-led?

Not sufficient evidence to rate

Leadership

- For our main findings please refer to the surgery report.
- The named lead for endoscopy services was also the infection prevention and control lead nurse. Support was provided to them by the corporate endoscopy lead. Staff told us that the service was training another member of staff to be lead for endoscopy.

Vision and strategy

- For our main findings please refer to the surgery report.
- The 2018 strategy for medical care was incorporated into the wider service strategy and presented on a poster in all departments. Oncology and chemotherapy service plans were also presented in the 2017/2018 quality account.

Culture

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

Governance

- For our main findings please refer to the surgery report.
- A specialist oncology nurse was appointed in February 2018, to drive the governance agenda for chemotherapy services.
- We saw that ward, oncology and endoscopy staff participated in the daily ward 'huddle' and that any specific risks or issues were communicated on a daily basis.
- We were told by oncology staff that oncology team meetings were scheduled every six weeks and there was representation at bi-monthly cancer services meetings at the NHS trust hospital. The staff said they also attended six-monthly cancer governance meetings.
- We saw evidence that the oncology lead nurse attended the hospital Infection prevention and control meetings and the hospital clinical governance meetings.
- Decontamination and endoscopy were noted to be a fixed agenda item in the Clinical Governance minutes provided.

Managing risks, issues and performance

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

Managing information

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

Engagement

- For our main findings please refer to the surgery report.
- Oncology patients were invited to attend a question and answer session with an oncologynurse, prior to commencing chemotherapy. They were encouraged to bring along a family member or friend to support them and were given as much or as little information as the patient wanted to receive. This enabled patients to give their informed consent to treatment.

Learning, continuous improvement and innovation

- For our main findings please refer to the surgery report.
- We saw how the service was working to meet the needs of patients with dementia and that staff were committed to delivering person centred care. This work had been recognised with a national award.
- Oncology patients received individualised care with the support of an established multidisciplinary team and this was recognised through achievement of Macmillan accreditation.

Good

Surgery

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

Information about the service

Surgery was the main activity at the service. Where our findings also apply to both activities, we do not repeat the information but cross-refer to the surgery section of the report.

Summary of findings

Our rating for surgery improved. At our last inspection we rated surgery as requires improvement. At this inspection we rated surgery as good overall because it was safe, effective, caring, responsive and well led.

We saw patients were treated with care, compassion, and respect by all staff during their treatment and patients told us that they were fully involved in their care.

The hospital used and audited the 'five steps to safer surgery' checklist. Spire Hull and East Riding Hospital provided care and treatment in line with national guidance and best practice. We found infection prevention and control processes were in place and robust, audits took place and compliance rates were high. Mandatory training compliance rates were high.

Although there had been a never event, the patient was fully informed and duty of candour (DoC) applied, with learning shared with staff and managed appropriately. Root cause analyses were completed for all serious incidents, learning identified and action plans put in to place to prevent recurrence.

There were staff vacancies at the hospital but all shifts had been filled and this did not affect patient care. We did identify some discrepancies in patient records and medicines management. These were addressed immediately by senior managers at the hospital.

Good

Surgery

Are surgery services safe?

Good

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

Mandatory training

- The hospital set target for mandatory modules of 95% for all staff by the end of the calendar year. We were told all staff must complete annual mandatory training, both on line and face to face as appropriate. Staff said they had undertaken all mandatory training required for their role.
- Information provided showed the target had been met for all mandatory training modules at the end of 2017, for example equality and diversity (98%), fire safety (98%), infection control (97%), safeguarding adults levels one and two (97%) and safeguarding children levels one and two (96%).
- We reviewed mandatory training compliance rates at the time of inspection when it would be expected that approximately 75% of staff would have completed mandatory training, in line with the calendar year training programme.
- All modules of training were ahead of trajectory to achieve the expected level of 95% by the end of the year. For example, health and safety (84%), manual handling (90%), safeguarding children levels one and two (82%) exceeded trajectory.
- The registered manager was responsible for monitoring compliance with training by clinicians working under practising privileges and who had received mandatory training from their substantive employer.
- During review of personnel documents we received assurance this monitoring was being undertaken - mandatory training records were completed and checked with substantive employers.

Safeguarding

- There was a safeguarding adults policy (October 2016) and a safeguarding children policy (June 2017) in place at the hospital and these were supported by clinical, departmental, safeguarding and education strategies. The policies identified the responsibilities for the safeguarding responsible manager (hospital manager) and the safeguarding responsible person (matron or deputy).
- The hospital provided adult safeguarding training and children safeguarding training to all staff which included Deprivation of Liberty Safeguards (DoLS) and counter terrorism training (PREVENT). This was mandatory at level two for every member of staff.
- The hospital had appropriate policies to support staff to safeguard adults and children and young people. The policy also included guidance about the national PREVENT strategy. PREVENT is part of the government's counter terrorism strategy and aims to stop people becoming terrorists or supporting terrorism.
- The safeguarding lead for adults and children and young people at the hospital was the clinical lead. We spoke with this member of staff who was able to clearly define their responsibilities in relation to safeguarding adults and children. The lead told us that they attended the Local Safeguarding Children Board (LSCB). These are a multi-agency body set up in every local authority. Where necessary we were told the lead would also liaise with the clinical commissioning groups.
- The hospital safeguarding lead accessed appropriate safeguarding supervision from a safeguarding professional who was external to the hospital.
- All safeguarding incidents at the hospital were reported through the electronic incident reporting system, all immediate actions taken to safeguard the individual were logged and a referral sent to the local authority safeguarding team.
- The safeguarding lead gave good examples of recent safeguarding cases and how these had been appropriately managed by the hospital teams. All safeguarding referrals from the hospital were discussed through the clinical governance committee, the clinical effectiveness committee, at the relevant departments team meeting, the heads of department meetings and the medical advisory committee to ensure shared learning.
- All consultants at Spire Hull and East Riding Hospital, including anaesthetists, who wished to have practicing privileges to deliver care and treatment were required to undertake safeguarding training. One of the consultants was the named doctor for safeguarding.

- The hospital was in the process of ensuring all safeguarding training at level three was delivered in accordance with 'Adult Safeguarding Levels and Competencies for Healthcare, Intercollegiate guidance (2016)'.
- Staff interviewed had a clear understanding about what constituted abuse and the action to report and record allegations of abuse.
- Information provided showed there had been one safeguarding concern raised at the hospital in the three months before inspection and this was related to a 'was not brought' patient for a MRI Scan. A safeguarding referral was made to the local safeguarding team.

Cleanliness, infection control and hygiene

- At our inspection in 2015, we found systems to ensure compliance with IPC standards required improvement. The governance lead was the IPC lead; however, they had no formal qualification for this role.
- We discussed the concerns from the previous inspection and were assured that changes had been made to improve IPC measures within the hospital. At this inspection the matron was the director of infection prevention and control (DIPC) and had an appropriate post graduate accredited qualification for this. In addition to this the hospital had internally appointed a lead nurse for IPC. This staff member did not have any formal qualification but was due to commence degree level accredited study in January 2019.
- The senior staff from the IPC team told us they were able to access help and support from a designated consultant microbiologist who was employed corporately on a service level agreement basis. In addition to this the lead nurse told us they had positive working relationships with the microbiology team at the local acute trust.
- Throughout the hospital we saw that the ward, reception areas, clinical and anaesthetic rooms and recovery areas were visibly clean and tidy. At the time of inspection works were being carried out to improve the building layout and decorative condition. The hospital had identified that the ward environment and theatres were 'tired' and was carrying out remedial maintenance. This also included the cardiac catheterisation department. We were informed that all areas would be subject to a deep clean when works were complete.
- The hospital infection prevention and control manual (November 2015), policies and procedures were based on Department of Health and Social Care's codes of practice on the prevention and control of infections.
- They included guidance on hand hygiene, the decontamination of reusable medical devices, the use of personal protective equipment (PPE) and the management of the spillage of body fluids.
- At our inspection in 2015, the hospital was not completing observational hand hygiene audits. They were measuring compliance based on hand sanitiser use. At this inspection the hospital had changed the audit processes and we found that they were completing observational hand hygiene audits. The outcome of these and action plans were shared with staff through team meetings. Both the ward and theatres showed compliance above 90% for the first two quarters of 2018.
- The observational audit measures were introduced in 2016 in line with NICE guidelines. There was a decline in compliance between April and June 2018. In response additional hand hygiene audits for the ward were implemented, with audits completed at different times of the day. Preliminary results showed good compliance on the ward and in other departments and this close monitoring was being continued.
- We saw that staff adhered to 'arms bare below the elbow' policy in clinical areas and used PPE as appropriate.
- Specialised ventilation is a statutory requirement in operating departments and a clinical requirement to reduce surgical site infections. Increased health risks to patients will occur if ventilation systems do not achieve and maintain the required standards. The link between surgical site infection and air quality is well established (Health technical memorandum 03-01: specialised ventilation for healthcare premises).
- The 'Health Act 2006: code of practice for the prevention and control of healthcare associated infections', sets out criteria by which managers of providers are to ensure that their NHS patients are cared for in a clean environment and where the risks of infection is kept as low as possible.
- We reviewed ventilation verification reports and noted five achieved greater than 75% of the original design parameters as required in 4.16 HTM 03-01-part B. The

exception (December 2017) was theatre four where building works had removed the anaesthetic room and changed that area into a 'layup preparation room'. Remedial maintenance had been advised and actioned.
- At the previous inspection the design of the main theatre suite had caused issues for patient access, staff and visitors into the intensive care unit, theatre flow and etiquette principles were compromised. These issues had been addressed.
- Antibacterial hand gel dispensers were available at the entrance and within clinical areas and the ward. We saw staff used these and washed their hands between patient contact.
- We saw a clinical wash hand basin seal was compromised but we were told this sink was due to be replaced during scheduled refurbishment taking place at the time of inspection.
- Staff completed cleaning rotas on a daily and weekly basis covering clinical areas such as theatres, outpatient department and the ward.
- There was an infection prevention & control (IPC) lead and an IPC committee responsible for ensuring that the hospital complied with effective IPC requirements. The hospital demonstrated effective patient outcomes for surgical site infections, venous thromboembolisms (VTE) and pressure ulcers.
- Staff followed guidance Sharp Instruments in Healthcare Regulations (2013) on sharps management and bins were clearly labelled and tagged to ensure appropriate disposal and prevent cross infection.
- Access to theatres was restricted and there were separate clean and dirty utility areas to reduce the risk of infection.
- Information provided for 2018 showed there had been four surgical site infections. The hospital reported one incident of Methicillin-resistant Staphylococcus aureus (MRSA) to the CCG, though the investigation was inconclusive as to whether this was hospital acquired. There had been no incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA), hospital acquired Clostridium difficile (C.diff) or hospital acquired E-Coli.
- All surgical patients were screened for MRSA pre-operatively. Information provided by the hospital did not indicate compliance rates for screening. However, we noted from minutes from the IPC committee meeting that outcomes were documented, the minutes showed one patient had their surgery delayed to allow for suppression therapy. A further 27 patients had been given suppression therapy pre-operatively and their surgery carried out as planned.
- The hospital had an onsite sterile services department which was accredited by SGS, where all reusable equipment was processed. The service was subject to regular inspections, the most recent being at the time of our inspection. There were policies, work instructions and risk assessments linked to the management of the service, which were approved by SGS and used nationally across the Spire group.
- Water testing processes were in place and governed by policies.

Environment and equipment

- Clinical areas were well maintained, bright, secure and welcoming. The hospital had four theatres, one ward, outpatient and consulting room facilities.
- The inpatient environment was tidy; however, some communal fixtures were found to be damaged with laminate peeling off and varnish chipping present. All rooms had access to showers and toilet facilities.
- Daily checks of all resuscitation equipment were carried out and records of these were seen during the inspection. Resuscitation trolleys were kept in a secure area with tamper proof tags.
- We saw that all equipment used during surgery had been safety tested, calibrated and serviced; records of these checks were kept.
- Processes were in place to record the unique identifying labels in patient notes enabling implants and single use instruments to be traced.
- All equipment, such as wheelchairs and hoists, used in theatres had been serviced and were in good order.
- The difficult-intubation equipment trolley was in the corridor for easy access when required. However, there were several gaps in the log of daily safety checks, so the service was unable to evidence that the emergency equipment was always fit for use when the department was open. For example, there was no record of checks on 11 occasions in the last three months. The theatre manager was present and noted the gaps.
- We reviewed patient led assessment of the care environment (PLACE) audit results and noted that the environment was scored at 87%, the same as the national average.

- We saw that clinical and non-clinical waste was segregated, stored and disposed of appropriately.
- We spoke with the engineering services manager and were told the hospital had a planned maintenance programme in place. The progress of the work was reported to the hospital director and the regional and national engineering leads. In addition to this, compliance reports were submitted locally and nationally for environmental safety testing, for example water safety testing, fire risk assessments and air safety tests.

Assessing and responding to patient risk

- The hospital followed clear admission criteria. All patients were referred for treatment by their GPs or self-referred.
- Pre-operative assessment was undertaken, information shared with patients and diagnostic investigations were undertaken prior to any decision on whether surgery would be offered. This took account of high risk patients, for example such as those with higher body mass index.
- Staff used a national early warning score tool (NEWS) and pain scores to manage deteriorating patients and escalate concerns to the resident medical officer (RMO), surgeon or anaesthetist when necessary. We saw that NEWS charts were completed in the records we reviewed.
- Local audit showed 100% of patients on the ward had full compliance with the national early warning score recorded within their notes between January and March 2018 and 97% compliance between April and June 2018.
- Within theatres and recovery 100% of patients had full compliance with the national early warning score recorded with their notes between January and March 2018 and 98% compliance between April and June 2018.
- Staff we spoke to were aware of their responsibilities in relation to escalating the needs of the deteriorating patient. We reviewed the process for escalating and transfer of the deteriorating patient. The hospital had an agreement in place with the local NHS provider to accept emergency patients requiring further treatment.
- The World Health Organisation (WHO) surgical safety checklist ('five steps to safer surgery') is guidance to promote safety of patients undergoing surgery. This sets out what should be done during every surgical procedure to reduce the risk of errors.
- We were provided with results of WHO audits for theatres which showed 95% compliance. We also observed surgeons working well with the theatre team to ensure that the WHO recommendations for theatre safety were followed and that there was emphasis on the management of specific risks.
- We saw that staff were fully engaged in the process and patients were also involved as appropriate. A designated member of staff ensured all swabs, needles and instruments used were counted and recorded during and after surgery.
- We observed patient handovers to theatre complied with procedures, with the patient consented, marked or being handed over to theatre staff in an appropriate way.
- The surgeon marked the specific site before surgery in accordance with the WHO checklist and involved the patient in this process. After surgery handovers were managed safely and staff informed patients of ongoing monitoring and care. Staff confirmed the recovery of patients before they were transferred to the ward.
- The previous inspection found issues with the use of the world health organisation (WHO) surgical safety checklist in interventional radiology. During this inspection staff we spoke with told us that the safety checklist was used for interventional radiology and had recently started using it for some ultrasound procedures. The world health organisation safety checklist was audited.
- Audits showed 100% of patients had their temperature maintained at 36^0 or above during the intraoperative phase of their procedure.
- Following surgery patients were provided a 24-hour helpline for advice and this included direct access to the surgeon. Following surgery, consultants gave patients their contact details and patients told us they felt reassured that help was available if needed.
- The hospital had protocols for transfer to the local NHS trust for patients whose condition deteriorated and required acute care and support. Two patients had been transferred within the last twelve months, a rate of 0.1 per 100 patient attendances, which was an improvement from our previous inspection when we saw 13 patients were transferred out.
- Venous thromboembolism (VTE) screening rates were good with 99% of all patients screened in the last twelve months. Three incidents of VTE or pulmonary embolism (PE) were reported in the same period.

- A sepsis policy was in place and staff had completed training in the recognition and management of sepsis.
- The hospital had recently introduced massive haemorrhage and sepsis equipment trolleys. This meant that staff had immediate access to all necessary equipment. The latest guidance had also been laminated and attached to the trolleys to provide a quick reference guide.
- We saw all safety alerts (medical devices, patient safety, '48-hour flash' alerts and Medicines and Healthcare Products Regulatory Agency (MHRA) alerts) and learning from complaints were detailed in a monthly safety bulletin to all staff.

Nursing and support staffing

- The hospital provided information which showed it employed 4.1 registered nurses (32.4 whole time equivalent) for every healthcare assistant employed (eight whole time equivalent) within inpatient departments including the ward.
- The ward duty rota was planned in advance by the ward sister taking into account patient dependency calculated using an adaption of the 'Shelford Safer Staffing Tool' and the algorithm developed through 'Safe Staffing for Nursing in Adult Inpatient Wards' (2014).
- An average of 7% bank registered nurses and 14% bank healthcare assistants were used over the six months before inspection. The hospital did not use agency staff during the same period.
- The hospital provided information which showed it employed 0.8 registered nurses (17.5 whole time equivalent (wte) for every registered operating department practitioner and healthcare assistant employed (22.7 wte.) within theatres.
- An average of 6% bank and agency registered nurses were used within theatres over the six months before inspection.
- Information provided also showed 14% bank and agency operating department practitioner and healthcare assistants were used within theatres over the six months before inspection.
- Over the last twelve months there was a vacancy rate of 6% for registered nurses and 12% for healthcare assistants on the inpatient ward.
- At the time of our inspection there were approximately 6 wte vacancies in theatres.
- Between August 2017 and July 2018 there was a staff turnover rate of 24% for theatre nurses and 46% for operating department practitioner and healthcare assistants.
- There were no unfilled shifts within the three months before inspection within theatres or on the inpatient ward.
- The hospital identified their staff needs in advance and ensured these were met within theatre, recovery, outpatient clinics and ward.
- We saw there were adequate and safe numbers of skilled staff in all areas and this was confirmed by patients, relatives and carers.
- The hospital offered elective services only with all patients pre-booked to access services, which allowed for effective planning of staffing to meet patient needs. Patients were booked through an electronic system with planned admissions and patients requiring additional support or staffing skills discussed at the daily heads of department briefing.
- Specific nursing needs identified during patient pre-assessment (for example requirement for extended recovery or closer observation) were communicated to the ward.
- Theatres complied with the standards and guidelines for minimum staffing developed by the Association for Perioperative Practice.

Medical staffing

- The hospital employed medical staff under practising privileges approved under comprehensive policies and procedures by the medical advisory committee (MAC).
- The granting of practising privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic, in independent private practice, or within the provision of community services
- The MAC provided medical supervision and was responsible for reviewing and monitoring clinical practices for the service.
- The hospital's process for granting practising privileges included checks with the disclosure and barring service (DBS), General Medical Council (GMC) registration and appropriate qualifications.

- Medical on-call cover on the ward was provided by the consultant in charge of the patients' care 24 hours a day for their admitted patients. An RMO was onsite at all times for immediate medical review and assistance as needed.
- Each clinician (surgeons, anaesthetists, physicians and radiologists) was required to document cross cover arrangements in the event they were unable to be contacted. This information was stored on their profile and reviewed biennially. Arrangements were in place for cover for any surgeon who had recently undertaken a theatre list in case a patient needed to be readmitted. It was also a requirement for consultants to remain on-call while they had a patient in the hospital and to attend on request.
- A hospital wide contact list was maintained for all doctors with practising privileges and the consultant surgeon was responsible for ensuring alternative anaesthetic cover if their usual anaesthetist was not available.
- Out of hours cover for each discipline was provided by the respective consultant and the hospital had a residential medical officer (RMO) on site at all times. The RMO provided medical assessment and treatment as required until the consultant was contacted. Ward staff were able to ring the consultant surgeon, anaesthetist or physician directly if they are required out of hours treatment.
- If a radiologist was required, this was initiated by the consultant surgeon or anaesthetist or the on-call radiographer. Radiologists informed relevant consultant surgeons and the head of department for radiology when they were on annual leave.
- **Records**
- Patients' records were kept in paper format and stored securely and complied with the Data Protection Act 2018 and the General Data Protection Regulation (GDPR). The hospital was registered with the Information Commissioner's Office.
- Ten patient records reviewed included pre-operative risk assessments for falls, pressure and skin integrity and where necessary care plans had been developed in response.
- Records contained detailed information of care and treatment including consent, investigations and test results and care plans. We reviewed ten sets of patient records and noted that not all entries had been dated, timed and signed by the relevant clinician. This was notified to the ward sister and action taken immediately.
- The surgical register in the operating theatre was completed and recorded procedures undertaken, names of surgeon and scrub nurse, the time each patient entered and left theatre, the patient's name and unique identifier as well as implants and swab counts.
- Administrative staff ensured patients' records were available for clinics and day case admissions. The hospital confirmed 100% of patients were seen with all relevant medical records available in the three months before inspection. Staff confirmed there had not been any instance of records not being available.
- Local audits confirmed patient records contained a documented pregnancy test prior to surgery, when appropriate (99%), national early warning score (100%), pain score (100%) and a daily evaluation made in the medical records by the consultant which is signed and dated (98%).
- A biennial review of activities undertaken, behaviours and clinical appraisal information (complaints, incidents, compliance with documentation) was completed for each consultant's practice by the hospital director, matron and MAC representative. This was completed annually for consultants treating patients under 18 years.

Medicines

- The hospital had policies in place for the provision of patients' medicines and we saw emergency drugs were available in case they were needed in the operating theatre and also on resuscitation trolleys. These medicines were in date and trolleys had been checked regularly as per policy.
- Access to pharmacy was available on-site, and a member of pharmacy staff attended and reviewed medicines for ward-based patients daily. Out-of-hours arrangements were available, and staff were aware of how to access medication.
- All medicines were stored safely and securely. Processes were in place to ensure these were safe for use, for example expiry date checks. These included the recording of receipt, storage, use and reconciliation of medicines.

- We also carried out checks of controlled drugs and found these were in date and entries in the controlled drug (CD) register were completed appropriately with two staff members' signatures in compliance with hospital policy.
- All medication cupboards were appropriately locked and keys held by nursing staff. Intravenous fluids were stored in locked cupboards and CDs were stored securely in wall mounted cabinets.
- Although the CD register was labelled 'not for oxycodone and tramadol', these drugs were recorded in the register because they had been transferred across from another register. The title on the register could cause confusion.
- There was evidence that the CD register was checked and audited regularly by a pharmacist. Medication names were written in full at the top of each page and wastage was recorded correctly.
- We reviewed prescription records and noted there were regular reviews by a pharmacist but there was evidence of some discrepancies. For example, we saw some prescriptions were not signed by the doctor but had still been given by nursing staff. This was bought to the attention of the nurse in charge and an action plan to address these issues was given to the inspection team later that day.
- CD checks were conducted by the night team and these checks were recorded in a separate book.
- Patients' own CDs were recorded in a separate register. There was good compliance in completion of all the fields in the register and evidence that the register was audited regularly by a pharmacist.
- Dedicated fridges were used for the storage of medicines and fridge temperatures were monitored to ensure medicines were stored correctly.
- Within the anaesthetic room the CD register was not labelled with the anaesthetic room number; when archived or if removed from the room, it was unclear which CD cabinet the book related. There was evidence of weekly audits of the CD register by a pharmacist. However, some fields in the register were not always completed correctly.
- Balance checks were recorded in the register and there were no gaps in the checks other than when the department was closed.
- Staff were able to access medicines out of hours from the hospital pharmacy. The hospital policy required two signatures, one of which would be provided by the RMO, when staff needed to dispense medicines.

Incidents

- Policies and procedures for incident reporting were available to staff and they were confident in using the system to report and record these.
- There had been one never event in the last twelve months. The patient was admitted for examination under anaesthesia, arthrogram and injection to the left hip however this was performed on the right side in error. The patient was fully informed and duty of candour (DoC) applied, with learning shared with staff and poor performance, staff and consultant, managed appropriately.
- Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with had received training and had a good knowledge of the procedure to follow.
- The hospital reported 828 clinical incidents between July 2017 and June 2018. Of these 823 resulted in no harm, low harm or moderate harm. During the same period the hospital reported 189 non-clinical incidents.
- All incidents and near misses were reported onto the electronic system and investigated with serious incidents requiring investigation (SIRI) subject to root cause analyses (RCA).
- There were mechanisms to ensure lessons learned were identified and improvements made were necessary. We saw that RCA were undertaken for all serious incidents requiring investigation and lessons learnt, recommendations and shared learning formed part of the root cause analysis.
- Five staff had completed RCA training in 2018 to ensure the quality and management of RCA investigations.
- We saw one investigation had identified key safety and practice issues which may not have contributed to the incident but from which others could learn. This

included actions to increase ASA grading awareness and training, completion of documented anaesthetic reviews and anaesthetic charts, multi-disciplinary team co-ordination for patients with multiple co-morbidities and internal process review for evidencing anaesthetic reviews are documented.
- The analysis also identified good practice, for example the sepsis six bundle was started immediately and was in line with hospital policy.
- We attended the daily safety huddle for all heads of departments led by the hospital director. The huddle was well structured and involved department leads from all areas. The huddle gave heads of department the opportunity to identify any pressures within their departments, escalate or de-escalate risk and share important information for the day that was relevant to other departments.
- Heads of department were observed to be fully engaged with the meeting and this was a method to promote patient safety and experience as well as a way of engaging staff in the running of the hospital.
- During inspection we saw comprehensive and effective handovers.
- Incidents were discussed at the medical advisory committee (MAC) and learning was shared locally through staff meetings. Incidents discussed at the MAC were raised with the relevant surgeons by the registered manager.

Safety Thermometer

- We saw a safety thermometer board displayed in a corridor outside the ward. This showed the number of falls, pressure ulcers and venous thromboembolism and the number of days since the last incident.
- The scorecard identified the key measures for the hospital compared to the national average for the group and demonstrated performance of the hospital compared to others in the group.
- This showed better performance for the hospital, than the rest of the group, in surgical site infections (both knee and hip arthroplasty), falls (2.25/1000 bed days) and venous thromboembolism incidences (three). The only measure worse than the rest of the group was for pressure ulcer incidence 0.56/1000 bed days, compared to a group score of 0.2. However, it was noted that the above figure equated to only one incident of pressure damage.

Emergency awareness and training

- The hospital was not a receiving area for major incidents.
- The hospital had a business continuity plan in place which provided the hospital with recovery procedures to re-establish business operations following a major business interruption, leading up to a total loss of premises.
- The plan identified roles and responsibilities of all staff in an emergency situation, the composition of the internal emergency response team and the local response and recovery team.
- The plan also identified incident alert and escalation procedures, evacuation procedures during working hours and the emergency response outside working hours.
- The plan had been tested through resuscitation and paediatric scenarios.
- The hospital had a contract in place with a private company to urgently deliver blood if required.

Are surgery services effective?

Good

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

Evidence-based care and treatment

- The hospital used evidence-based care pathways as commissioned and developed by the company's head office. Care pathways were based on clinical guidelines from established and recognised bodies (for example National Institute for Health and Care Excellence) and covered a range of procedures.
- The hospital had a clinical audit programme and clear approach to policy management. The hospital completed national and local audits and discussed these at relevant governance meetings.

Nutrition and hydration

- The hospital collected and reported patient feedback on pain relief, nutrition and hydration and staff competency as well as a number of other measures through the patient feedback form.

- Staff used pre-operative fasting guidelines for adults in accordance with the recommendations of the Royal College of Anaesthetists (RCOA).
- Patients' confirmed they were given clear information about fasting prior to surgery, including patients who were receiving sedation or anaesthetic.
- The number of patients fasted for two hours or less prior to surgery (Royal College of Anaesthetists guidelines) was monitored quarterly through the clinical scorecard and based on a local audit of patient medical records. This showed the hospital averaged 93% of patients fasted appropriately.
- Guidelines for fasting had been reviewed and updated to reflect latest guidelines and the pre-operative assessment team advised patients about appropriate fasting.
- Patients' dietary needs were assessed and they were offered a variety of meals to meet their individual needs. There was a wide choice of options in terms of food, with individual needs catered for and the safety huddle checking whether any admitted patients had dietary requirements.
- In the care records we reviewed, we saw that fluid balance charts were included, where appropriate, and these were completed in full.
- Patient dietary requirements were managed well and there was a separate children's menu.
- Diabetic patients were identified at pre-operative assessment and an individual care plan developed with the surgeon and anaesthetist.
- The catering manager told us he was proud that every dish created in the kitchen was made 'from scratch' for the patients.

Pain relief

- Patient feedback on pain relief was benchmarked against other hospitals within the company and showed the hospital was above the national group average.
- Patient's pain scores were checked with patients and documented by staff and appropriate pain relief provided. We saw that intentional rounding checks on patients and their pain relief needs were carried out.
- Staff assessed patients' pain in the recovery area and patients confirmed that their pain was monitored and treated appropriately. Patients' pain was assessed during and after procedures.
- Local audits showed 100% of patients had pain scores recorded within their notes in the six months before inspection.
- We saw nursing staff provided patients with advice on pain relief when preparing patients for discharge. Patients were given a 24-hour helpline number to contact their surgeon and also advised to contact their local accident and emergency department if pain persisted.
- Hospital consultants and the RMO were available to provide advice if patients complained of pain after surgery.

Patient outcomes

- The hospital used a range of tools to monitor and benchmark performance against targets, other hospitals and providers. These included, for example, the national clinical scorecard, children and young people's dashboard, and national audit programmes for effective management of cancer patients.
- The hospital reported effective patient outcomes for various measures including surgical site infections, venous thromboembolism (VTE), pressure ulcers and returns to theatre.
- A number of patient outcomes were measured and reported through the company's clinical scorecard. These were linked to external benchmarks and compared against other hospitals for trends.
- Data sets included returns to theatre, readmissions, transfers, surgical site infections, VTE, falls and pressure ulcers. The hospital had an action plan to address any concerns and provided evidence of improvement over time with many of the scorecard measures.
- The hospital submitted data to national audits to allow results to be monitored and benchmarked. For example, the hospital participated in the patient reported outcome measures (PROMS) for hip and knee replacement and the national bariatric registry.
- Patient improvement was measured following hip and knee replacement by Oxford hip/knee score (experience of pain and ability and/or confidence in completing everyday tasks), EQ-5D (general health) and EQ-VAS (visual, general health).
- Data reported to the National Joint Registry showed 'as expected' patient reported outcomes for both hip and knee replacements.

- For hip replacements the hospital scored health gains of 20.98 Oxford score (national average 21.77), 0.449 EQ-5D (national average 0.444) and 12.41 EQ-VAS (national average 13.40).
- For knee replacements the hospital scored health gains of 15.50 Oxford score (national average 16.52), 0.327 EQ-5D (national average 0.323) and 8.44 EQ-VAS (national average 6.98).
- The hospital measured 'as expected' for 90-day mortality rates and revision rates following surgery for both hip and knee replacements.
- The hospital also monitored patient outcomes for cosmetic procedures by using QPROMS developed by the Royal College of Surgeons. These gave a patient's measurement of their health and health-related quality of life before and after surgery. The hospital provided data for rhytidectomy (facelift), abdominoplasty, blepharoplasty, liposuction, rhinoplasty and augmentation mammoplasty.
- All procedures scored much better on average in the post-operative questionnaire than in the pre-operative questionnaire with an average gain of 2.46 and an average post-operative score of 3.90. All patients responding to the post-operative questionnaire showed some improvement on pre-procedure scored.
- There had been five unplanned returns to theatre, 23 unplanned readmissions within 28 days of discharge and two unplanned transfers to other hospitals within the last twelve months (0.1 for every 100 patient attendances). This performance showed an improvement since our previous inspection.
- The clinical scorecard was used to benchmark the hospital against company comparators for key performance indicators.
- Performance was reviewed at the clinical audit and effectiveness committee, clinical governance committee and at the MAC. We saw actions were taken to reflect outcomes and performance.

Competent staff

- Records showed that 100% of nursing staff and operating department practitioners in post more than six months had their registration validated in the last twelve months.
- Newly appointed staff underwent an induction process including a supernumerary period at the start of employment.
- Bank staff had a longer induction and agency staff also went through a standardised induction checklist delivered by the senior nurse on duty.
- Data provided showed that 100% of ward and theatre staff had received an appraisal within the last twelve months.
- Consultants worked at the hospital through practising privileges which were reviewed every year by the senior management team and the MAC. This review included appraisal and performance. Resident medical officers (RMO) provided on-site continuous medical cover for the hospital.
- Consultants provided training to nurses and junior colleagues at their employing NHS trust and attended local and national conferences to maintain their skills and knowledge.
- All clinicians had an annual performance assessment with their NHS employer as part of their fitness to practice and this was shared with the hospital.
- All consultants limited their practice to those sub-specialist areas that they also practice in the NHS. Any patient who presented with a condition outside of their sub-specialist expertise was referred on to an appropriate clinician.
- During the inspection we heard that several staff roles, for example the infection control lead nurse, the governance lead and the risk lead, had been implemented without any formal recruitment process. We discussed this with the hospital director who provided assurance about the process and explained the roles were not vacancies and were therefore not advertised.

Multidisciplinary working

- Local audits showed 100% of cancer patients had evidence of multi-disciplinary team discussion recorded within their notes.
- The daily safety huddle for all heads of departments was led by the hospital director and involved department leads from all areas. The huddle gave heads of department the opportunity to identify share important information for the day that was relevant to other departments.
- Heads of department were observed to be fully engaged with the meeting and this was a method to promote patient safety and experience as well as a way of engaging staff in the running of the hospital.

Good

Surgery

- All consultants had a good working relationship with the ward and theatre teams and followed common processes.
- We saw effective multidisciplinary working between staff of all grades at the hospital. Professional relationships between all staff promoted the values of the hospital and staff said they felt valued and worked well together.
- Treatment was well co-ordinated between theatres, departments and ward, patients confirmed their treatment was seamless when transferred between departments and wards.
- We saw the ward functioned effectively and patients were prepared for theatre and discharged effectively.

Seven-day services

- Surgery was performed during weekdays, evenings and at weekends. Within all theatres the first case began at 7:30am and completion and shut down was normally by 9pm.
- Theatres had the potential to function six days a week as service demanded. The designation as the emergency theatre was assigned to the room with the lightest work load on the day.
- Physiotherapy and imaging services were available seven days a week, and occupational therapy was available through the week.

Are surgery services caring?

Good

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

Compassionate care

- All patients admitted to the hospital were asked to complete an online feedback survey. Results were collated and reported by an external provider and shared monthly within the hospital.
- The hospital was proactive in seeking patients' views and their experience of care and treatment. During the inspection we saw a large number of complimentary letters and cards about the service.
- New questionnaires had been introduced to ensure specific service level feedback in response to low response rates of external online surveys, such as the 'Friends and Family test' (FFT). These were in place for endoscopy, imaging, extended recovery unit, dementia services, children and young people services and cancer services.
- FFT audits of patient feedback provided showed that 98% of patients said they would recommend the hospital to a friend or relative. However, the response rate was low (between 10% and 24%).
- We saw there were high levels of patient satisfaction, evidenced through surveys and compliments received.
- We saw that patients were treated with care, compassion, and respect by all staff. During the inspection we observed patients were greeted professionally on their entrance to the hospital and directed to the relevant service.
- The hospital promoted privacy and dignity for patients, particularly when they were transferred from trolleys and chairs. A further example was that colonoscopy patients were provided a bedroom on the ward to promote privacy and dignity rather than in shared day care bays.
- All patients said their privacy and dignity needs were respected. One patient said staff always knocked before entering the bedroom and we saw that patient names were not displayed on the doors or on the ward allocation board.
- Patient led assessments of the care environment (PLACE) showed that privacy, dignity and well-being was scored at 85% compared to a national average for all acute providers of 83%.
- We saw that consultants greeted patients in a warm and friendly manner for their appointments and patients confirmed they had built up good relationships with their consultant.
- Patients spoken with were positive about the whole experience they had received. Patients said they had '…received excellent care' and that all their '…needs had been met'.
- The hospital collated specific feedback for core services through locally produced surveys for example children and young people, cancer services, endoscopy, diagnostic imaging and extended recovery unit.

Emotional support

- There was an established volunteer programme in place with 15 to 18 volunteers in the programme at any time.

Good

Surgery

- We saw medical staff explaining treatments and procedures to patients and saw that all questions were answered and patients given time to understand the responses given.
- Consultants confirmed they would give additional time to any patient who needed a longer discussion.
- Patients confirmed staff had supported them when they arrived for their procedure and felt reassured following discussion with staff and were well prepared for treatment.
- Patients had their pain managed very well, confirmed staff response times were very prompt when they used call bells and that they had seen their consultant every day.
- The hospital had developed a bereavement policy to support delivery of bereavement services for patients, relatives and carers within the hospital.

Understanding and involvement of patients and those close to them

- Patients told us they were fully involved in their care and treatment and they felt able to ask for further details and explanation about any aspect of their treatment.
- They told us treatment had been explained and their questions were answered fully by both nursing and consultant staff.
- Patients said they had been involved in their discharge planning, for example one patient was the main carer for their spouse and was very satisfied with the help received to ensure care needs were being met while in hospital and afterwards during convalescence.
- Relatives had been offered hot drinks and confirmed 'open' visiting times considered patient needs.
- We saw that family members were encouraged to be involved in care planning and delivery and contact cards for family were provided.
- We saw that patient notes recorded pre-operative discussion, confirmation of consent and contact during admission and post-operatively to provide support and information.
- Patients received information including the cost of surgery in writing prior to their appointment.
- We observed the surgeon and anaesthetist involved the patient in their surgical procedure and explained what they were doing to give reassurance.
- Written information about post-operative care was given to all patients and we saw staff talk to patients about their aftercare.
- Dementia champions were in place across the hospital and one to one nursing in place where required. The hospital also had adopted 'John's campaign' and 'Barbara's campaign' (campaigns to ensure staff have the skills to nurse dementia patients with sensitivity, compassion and empathy and support carers with compassion and respect).

Are surgery services responsive?

Good

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

Service delivery to meet the needs of local people

- Patients were referred to the surgeon of their choice where possible and seen by that consultant throughout their treatment ensuring continuity.
- The hospital offered surgery and outpatient appointments six days per week including evenings and weekends; appointment and treatment times were undertaken at a time suitable to the patient when possible.
- Pre-admission assessment appointments were provided in the evenings where clinically appropriate and to ensure effective planning of admissions.
- The hospital provided care and treatment including diagnostic procedures at the same location. The hospital had introduced a 'one stop' assessment process for patients prior to surgery, for example breast services and pre-consultation imaging.
- Patients had a consultation, examination and assessment in their first visit. This provided a comprehensive assessment that allowed the patient to be booked in for surgery without further visits.
- All surgical procedures were planned and the hospital did not provide emergency care; referrals were made to the local NHS trust when needed.
- A range of services were available for NHS patients where commissioners had identified capacity shortfalls or for patients who wished to exercise their rights of flexibility and choice.

Meeting people's individual needs

Good

Surgery

- We saw that open visiting times were promoted, and parents and carers were able to stay overnight with children where required.
- Designated car parking spaces for patients, carers and relatives with limited mobility were available. Toilet facilities were available throughout the hospital for patients, carers and relatives with a disability.
- There was personalised, patient-centred care provided for patients living with a dementia and their families which had achieved a national award. The hospital had dementia link nurses in place.
- The hospital offered access to translation services for patients where English was not their first language. The hospital had a local process to follow to access services as required through a national contract across the Spire Group.The process made it clear that family members could not be used as interpreters in line with best practice in any clinical matter.
- Spire Healthcare Limited consent policy gives advice for staff on when an interpreter is required and clearly notes that; 'it is not appropriate to use children under the age of 16 years and preferably not under 18 years to interpret for family members who do not speak English.'It was not clear whether this was for clinical matters and the provider advised this policy would be updated to make this clear.
- Patients were provided with information leaflets regarding risks and benefits of surgery and were able to review these before their procedure. Patients also had nurse pre-assessment at thesame visit.The 'one-stop' service minimised visits prior to surgery.
- There was a specialist nurse available to support patients undergoing breast surgery.
- During the inspection we were told that a patient experience committee was in the process of being established and that patient forums had been introduced and scheduled.
- We saw 'You said, we did' displays throughout the hospital which demonstrated learning from feedback and complaints and the changes made in response. Feedback had been used to provide positive feedback for staff and to improve services.
- A wide variety of leaflets and patient information was available throughout the hospital and particularly within the ward and inpatient areas.

Access and flow

- Patients were referred to the hospital by their GP, self-referral or NHS referral.
- Referral to treatment (RTT) data for July 2017 to August 2018 showed that 100% of patients commenced treatment within 18 weeks. This meant the hospital had consistently exceeded the standard of 90%.
- The hospital quality report (April – June 2018) showed there had been 2991 discharges (25% inpatient, 75%-day case) in that period. There was an average inpatient length of stay of 1.9 days.
- The physiotherapy team audited length of stay for joint replacement patients which they told us was currently a maximum of five nights. It was felt that the reduced length of stay was an outcome of the effectiveness of the whole pathway including pre-operative therapy groups in the outpatient physiotherapy department. The manager told us the hospital benchmarked as having a shorter length of stay than other Spire hospitals, the five-night target was achieved with 94% of patients.
- There was a process in place for patients who missed or did not attend their appointments as planned. Staff would contact them by phone and patients would be offered alternative dates as appropriate.
- We saw that 83 procedures were cancelled for a non-clinical reason from July 2017 to August 2018. Of these, 71% of patients were offered another appointment within 28 days of the cancellation.
- The reduction of avoidable cancellations was a priority for the hospital and processes and systems within the pre-operative assessment team were under review to ensure that all patients admitted for treatment had an appropriate assessment. An anaesthetic clinic had been introduced to reduce cancellations.
- Following the previous inspection, the provider confirmed that they were planning to access the critical care unit by a separate route to avoid the public entering the post anaesthetic care unit. This had been done and further building work was being completed during this inspection.
- Patient records confirmed staff completed appropriate discharge summaries and these were communicated to GPs in a timely manner.
- We followed patient journeys and saw patients were met at the reception desk in the main waiting area by administrative staff, prior to being escorted onto the ward. The patient was then admitted to their bed and prepared for theatre.

Good

Surgery

Learning from complaints and concerns

- Complaints were managed and overseen by the hospital director and clinical complaints specifically overseen by matron. The tracking of complaints was managed by the governance administrator who ensured documentation was uploaded to the electronic system, shared with relevant staff involved in the investigation and that timescales were met.
- Complaints were discussed daily by the senior management team and shared more widely with staff at the daily huddle.
- Complaints data and learning was presented at the MAC, clinical governance committee, clinical audit and effectiveness committee and relevant complaints were discussed in team meetings.
- The national company quality committee reviewed trends in complaints and hospital outliers as well as reviewing any level two and three complaints in more detail.
- Compliance with complaints targets was monitored and reported via the clinical scorecard and shared with the executive committee and the company board.
- Patients were able to raise complaints through the hospital's website, through patient feedback forms, patient forums, social media, verbally to any member of staff as well as in writing and by email.
- 'Please talk to us leaflets' explaining the complaints process were available throughout the hospital. On receipt of a complaint, an acknowledgement letter as well as the 'Please talk to us leaflet' was sent to the patient. These explained the standard timeframe for completion of investigation and response.
- It also advised that should the patient not be completely satisfied with the response from the hospital, they may escalate the complaint to level two (group medical director) for an independent review. Private patients were informed they could also contact the Independent Sector Adjudication Service (ISCAS) and NHS patients could raise a complaint to the relevant CCG and escalate unresolved concerns to the Parliamentary and Health Service Ombudsman.
- The company protocol for management of complaints was described in the complaints policy (HOP 02). The policy required all complaints to be acknowledged within two days of receipt and aimed for closure within 20 working days.
- The hospital had received 79 complaints (0.6/100 inpatient and day case attendances) since January 2018 and none of these had proceeded to the ombudsman or ISCAS.
- Data provided showed the hospital had responded to 91% of all complaints received for 2018 within 20 working days. This was significantly better than the company average of 72% and better than the target of 75%.
- Learning was shared with relevant departments and discussed in team meetings. A patient experience committee was being established to provide a more focused review for learning and action.
- 'You said, we did' displays demonstrated to patients and visitors learning and action taken from complaints. Examples of improvements made as a result included developing an onsite computerised axial tomography service, a physiotherapy gym, onsite pathology to reduce turnaround times, additional outpatient capacity, evening services and extra car parking.
- Feedback was also used for consultant appraisals to inform their feedback with any complaints shared with their appraiser.
- We spoke with an administrator who oversaw the complaints process. This staff member was aware of and worked to the corporate complaints policy. Informal complaints that were dealt with locally within the relevant department were forwarded to the administrator who kept a central log to ensure oversight.
- For shared learning, complaints were discussed at safety huddles, team meetings, the clinical governance committee, the audit and effectiveness committee, the medical advisory committee and also shared with all staff through the governance newsletter.
- The hospital director had responsibility for the oversight of all complaints. A quarterly report was presented at the clinical governance meeting and also sent to the corporate team. This report included details of time scales for managing and closing complaints.

Are surgery services well-led?

Good

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

Good

Surgery

Leadership

- The service had managers at most levels with the right skills and abilities to run a service providing high-quality sustainable care.
- The hospital had a clear management structure in place with clear lines of responsibility and accountability. The hospital's senior management team (SMT) consisted of a hospital director, matron, operations manager, business development manager and a finance and commercial manager. A governance and clinical lead were line managed by the matron.
- The matron was new in post however they had been employed by Spire, in another location for more than 18 years. Staff we spoke with were aware of the new appointment. The former matron had taken up the role of clinical lead. The matron told us they were being supported by staff at all levels including her predecessor.
- Within the organisation there were national, corporate leads in place to support the local leads, for example there was a corporate head of clinical education who supported the local lead for education and development. Corporate training days had been attended by the risk champion, in addition this member of staff had a monthly conference call with other risk champions and the corporate lead was also available for support.
- Staff of all grades told us the senior management team were extremely supportive, visible and approachable. Staff also told us the hospital director had an open-door policy.
- We spoke with the hospital director who was able to outline the key changes that had been implemented since our last inspection. This had included reconfiguration of some services, staffing changes including heads of departments and scaling back some services to ensure patient safety. In addition, the oncology and children and young people's services had been improved to enable increased activity.

Vision and strategy

- We looked at the hospital's strategy. This was in the form of a jigsaw and appeared to contain mission statements from all departments, rather than strategic objectives. We discussed this with the hospital director who explained that the purpose of the document was to engage clinical teams in their own strategic vision. The version in use at the time of our inspection was the first draft and this was being developed further, in conjunction with each service, in quarter four of 2018.
- The hospital had a robust clinical strategy action plan, this included actions and measures for each of the following objectives. To minimise avoidable harm, to provide a positive experience for all patients under our care, to communicate more efficiently, effectively and courteously with everyone, to strengthen nursing and shape professionalism and leadership, to employ excellent staff who feel valued and empowered to perform the best of their abilities and to empower staff to speak up when they have concerns about patient care.
- The hospital had an education and training lead person who had developed the hospital education strategy. The aim of the strategy was to ensure the development and commitment to clinical education to enhance staff's skills and knowledge.

Culture

- There is currently no requirement for independent healthcare hospitals to have a freedom to speak up guardian (F2SUG) however the hospital had appointed a member of staff to this role in February 2018. The role of the F2SUG is to ensure that staff have the capability to speak up effectively and are supported appropriately. We saw posters displayed throughout the hospital promoting the role of the F2SUG however we could not find any documentation to guide practice. We discussed this with the senior leadership team who told us the whistle blowing policy was being revised to incorporate the requirements.
- We spoke with the F2SUG who told us they had promoted the role by sending a global email to all staff and attending team meetings. In addition, October 2018 was freedom to speak up awareness month and they were planning to do further promotional work. However, they had not dealt with any cases since the role had been introduced. The guardian felt this was partly due to the approachability of senior staff.
- We looked at the hospital whistle-blowing policy and found that this was being reviewed and updated to include the information regarding the F2SUG.
- The lead for education and development told us the hospital invest heavily and are supportive of ideas for staff development.

- Staff of all grades spoke positively about the culture within the hospital and told us they were passionate about their roles and the hospital. Staff described the team as being 'like family'. One said they wouldn't have surgery anywhere else. Staff who had joined the hospital more recently told us they were made to feel welcome by the whole team, they said they felt like 'part of the family' and had been supported.
- Staff told us they were proud to wear the hospital badge, of where they 'were and where they were going', one recent recruit told us the hospital was the best place they had ever worked.
- Professional relationships between all staff promoted the values of the hospital and staff said they felt valued and worked well together.
- The chair of the medical advisory committee told us they were proud of the hospital and was honoured when they were asked to take on the role of the chair of the committee. The chair described the senior leadership team as having a 'can do attitude'.
- The newly appointed matron spoke positively of their first impressions of the hospital and described staff as being immediately welcoming, willing and receptive.

Governance

- At our inspection in 2015, we found that whilst there were governance structures in place for the provider and locally within with the hospital, these were not effectively implemented. We found there was a high element of trust and a low assurance culture.
- At this inspection we found that governance processes had improved and were more robust. The hospital held a quarterly clinical governance committee, an audit and effectiveness committee also met every six weeks. To improve governance and oversight a weekly rapid response meeting had been introduced as well as daily safety huddles.
- We attended the daily safety huddle for all heads of departments led by the hospital director. The huddle was well structured and involved department leads from all areas. The huddle gave heads of department the opportunity to identify any pressures within their departments, escalate or de-escalate risk and share important information for the day that was relevant to other departments. Heads of department were observed to be fully engaged with the meeting and that this was a valuable communication strategy to promote patient safety and experience as well as a way of engaging staff in the running of the hospital as a whole.
- All incident reports within the previous 24 hours were discussed at the safety huddles to provide assurance that immediate actions to mitigate further risks had been undertaken. Following this any incidents requiring escalation would be discussed in greater depth with the relevant head of department at the rapid response forum. Due to the rapid response meeting being recently introduced, it was not possible to report of the effectiveness of the process.
- We spoke with the newly appointed governance lead, who told us they had concerns that previously the mechanisms for ensuring the actions to mitigate the risks, following serious incidents, were not always completed effectively or that the hospital could not evidence that actions. The lead described this as being a priority for them but acknowledged they were not assured about the processes at the time of the inspection. However, they saw this as a priority. The lead told us that staff were encouraged to report all incidents including near misses so that any themes and trends could be identified.
- We reviewed the minutes of clinical governance committee meetings and found it was difficult to assess the effectiveness of the meeting, as the minutes referred to papers presented on topics and general points on the topic. There was no evidence of analysis, challenge or assurance.
- We asked senior staff we spoke with about the governance framework for their services. Each service lead was able to clearly define the arrangements and the reporting processes.
- At our inspection in 2015, there was a lack of effective oversight and action to ensure that incident investigations were of a high standard and root causes identified. We spoke with the MAC and clinical governance chair about root cause analysis and lessons learned following serious untoward incidents and were assured that the process had improved and was more robust.
- Since the previous inspection staff undertaking root cause analysis investigations had attended training. All serious incidents were investigated by the relevant head

of department and the lessons learned shared at the senior management team meeting, MAC and clinical governance as well as the relevant departments team meeting.

- The MAC chair provided assurance that clinical safety was a priority. They described some of the changes to processes that had occurred as a result of national high profile cases and from our previous inspection and gave several positive examples including the work to embed the WHO checklist procedure, RMO cover, the anaesthetic rota, the improvements in surgical pre-assessment now being in line with American Society of Anaesthesiologists (ASA) physical status classification system, the introduction of a safer staffing acuity tool and the audit and assurance processes.
- At our inspection in 2015, we found that attendance at the medical advisory committee was around 50%. At this inspection the chair of the committee confirmed that attendance was similar at around 50-70% however, we were told that representatives from each speciality did attend the meetings. The chair described the purpose of the meetings as being 'the critical friend' and was able to describe how practice had changed within the hospital because of the committee. We were told that new procedures were discussed at the meetings, all clinical incidents were also reviewed and any learning shared. The chair gave an example of a recent never event, that had had occurred in theatres, which was reviewed by the group.
- We reviewed minutes of the MAC meeting and found these were detailed and included comprehensive governance information.These were saved with restricted access to key staff on the hospital's shared drive as they contained some sensitive information, for example the details of doctors whose practising privileges were suspended.
- The MAC chair and the chair of the clinical governance committee, had a shared sense of purpose and a good working relationship.
- The MAC meeting and the clinical governance committee meeting were held on the same day and ran concurrently so that issues raised at the governance meeting could be shared at the MAC later the same day.
- At our inspection in 2015, the hospital policy was for staff to have a DBS review every 10 years. However, during inspection, on review of 10 personnel records, this did not always occur.
- At this inspection, we spoke with the hospitals local human resources (HR) contact, this was a member of the administration team whose role included supporting the senior team and heads of departments with staff performance issues, recruitment, complaints and the maintenance of the electronic systems used to monitor compliance with nursing and medical staff recruitment checks and professional body registration.
- We were not able to review any nursing personal files as these were off site at the time of our inspection and being uploaded on to an electronic system to meet the General Data Protection Regulation 2016/679 (GDPR). This is a regulation in European Union (EU) law on data protection and privacy for all individuals within the EU and the European Economic Area (EEA). It also addresses the export of personal data outside the EU and EEA areas.
- We looked at the system used to check that all registered nursing were compliant with revalidation for registration with the Nursing and Midwifery Council (NMC). We saw that this was a robust system which was checked each month.
- Consultants working at the hospital were utilised under practising privileges (authority granted to a physician or dentist by a hospital governing board to provide patient care in the hospital); these, with appraisals and other recruitment checks were logged on an electronic system. At this inspection we reviewed the system and saw that a robust checking process was in place. This included recording of recruitment processes, disclosure and barring (DBS) records, references, mandatory training and appraisals.
- Consultants who failed to provide evidence of their NHS appraisal or mandatory training had their practising privileges suspended until these were provided. We saw evidence of this documented in the medical advisory committee meetings.
- A biennial review of activities undertaken, behaviours and clinical appraisal information (complaints, incidents, compliance with documentation) was completed for each consultant's practice by the hospital director, matron and MAC representative. This was completed annually for consultants treating patients under 18 years.
- Staff explained there was a specific recruitment process in place for volunteers working in the hospital which included an application form, interview, references and an advanced DBS check. The minimum age for

volunteers was 18 years old. Volunteers were required to complete level 1 safeguarding training and PREVENT training and received initial information about safeguarding and who to contact if they had a concern, during their induction period. We saw evidence of the recruitment records for volunteers and were assured that a robust process was undertaken.

- At our inspection in 2015, we found systems to ensure compliance with IPC standards required improvement. Previously the governance lead was also the designated IPC lead, however they had no formal qualification for this role. At this inspection the matron was the director of inspection prevention and control (DIPC) and had an appropriate post graduate accredited qualification for this. In addition to this the hospital had internally appointed a lead nurse for IPC. This staff member did not have any formal qualification but was due to commence degree level accredited study in January 2019. We discussed the concerns from the previous inspection and were assured that changes had been made to improve IPC measures within the hospital.

Managing risks, issues and performance

- At our inspection in 2015, staff we spoke to expressed that their biggest worry was staffing levels and recruitment. We also had concerns that the hospital risk register required improvement.
- We found that the current risk registers still had some long-standing risks, for example risks that had been on the register for two years and also some that had little or no evidence of actions to mitigate the risk.
- We met with the risk champion at the hospital who described their role and the actions taken since taking up the role. This member of staff was approached by the senior team to become the risk champion earlier this year. At that time there were more than 200 risks on the hospital risk register, many were no longer relevant, had not been reviewed or did not have any actions to mitigate the risk. This was in line with our findings in 2015.
- The risk champion explained that with support from the corporate head of risk, they had stripped back the risk register in line with the corporate policy and ensured that the remaining risks were in line with the corporate policy. Clinical risks were rated in line with the national patient safety agency (NPSA) risk matrix guidance. Other risks included risks preventing the hospital from meeting objectives, reputational and financial risks. The risk champion explained that this was still a work in progress.
- All risk registers were created within the hospital's electronic reporting system, each service had their own risk register. Risks graded from one to six were managed locally by heads of departments, risks graded six to 12 were reviewed by the relevant member of the SMT and discussed at the clinical governance, SMT and the health and safety committee meetings.
- Each month heads of departments received a copy of their risk registers which they were able to display and to use for discussion at team meetings.
- The risk champion had arranged to meet with heads of departments and attend team meetings to explain the risk registers and how these should be reviewed and updated in line with completion of the actions to mitigate, on the electronic system. The risk lead was responsible for monitoring compliance with this and sending reminder alerts to the heads of departments where necessary.
- We spoke with the catering manager who described the actions taken to mitigate the risks in the catering service. This included the action plan to address allergen guidance, standard operating procedures for food storage to prevent cross contamination between raw and cooked foods, processes for the management of hot oil and purchasing of pre-sliced food for example meats, to reduce the need for staff to use knives.
- We were told that the hospital had access to a dedicated HR business partner who visited the hospital once a week and was available to contact on an ad hoc basis at all other times. In the event of a head of department needing advice in relation to a staff performance issue, the administrator was able to signpost to policies and advise of previous similar cases which could be referenced. We had some concerns that staff who were not trained in HR processes had this level of responsibility.
- There were no recorded risks for education and development on the risk register at the time of our inspection.

Managing information

Good

Surgery

- The hospital used a clinical scorecard with quality measurements. This was submitted to the local commissioners on a quarterly basis and was used to benchmark against other Spire hospitals.
- Accessible information standards posters were on display at the hospital. This informed patients to let staff know if they had communication support needs.
- All staff had access to the hospital intranet to gain information relating to policies, procedures, NICE guidance and e-learning.
- Minutes from meetings and important documents such as the hospital risk register could be accessed by staff on the intranet.
- Staff could access patient information such as x-rays, medical records and physiotherapy records appropriately through electronic and paper records.
- Compliance with information governance training for all staff was 78%, this was better than the September 2018 trajectory of 75%.
- We found that patient records were stored safely and securely away from patients and that there was a secure transport system in place for transferring records from one site to another.
- We had concerns that details of current complaints, including complainant names, were displayed on a white board in an administrator's office. Whilst this office was not in a public area, the area was not secure and the information was visible through a door window. We raised this with the relevant personnel and noted that the identifiable information was removed immediately and replaced with identification numbers instead.

Engagement

- At our inspection in 2015, senior hospital staff recognised that improving staff and consultant feedback was an area requiring improvement.
- At this inspection staff were seen to be passionate about their roles and invested in the success of the hospital. Staff we spoke with were engaged in the future of their services and the desire to be excellent providers of care. Some of the staff we spoke with were proud to have received recognition from their colleagues and managers for long service and or good work and achievement.
- All staff we spoke with felt valued by the hospital, their line managers and the senior management team. Staff gave examples of engagement activities and rewards the hospital offered these included; an annual staff party, a free birthday lunch, long service awards and inspiring people awards.
- Staff said the hospital director was 'always around the hospital and knows every body's name', that managers had an open-door policy and were very approachable.
- Other staff told us that work life balance was respected and that the investment in their training made them feel valued.
- We saw that where a staff member had a led on a piece of work such as reviewing, updating or writing a policy or treatment protocol they were clearly recognised for that work by being a named author on the document.
- The hospital director held a daily safety huddle for managers from all areas, which included special thanks from patients to staff and recognition of individuals' good work from other staff. Managers cascaded the key messages from the huddle to their own teams.
- Patient engagement occurred in several ways, for example, patient feedback was encouraged, and surveys were undertaken regarding patient experience and waiting times. Compliments were also collected and shared with staff and or used in appraisal and revalidation. All feedback was shared to promote improvement from a patient perspective and improvements were displayed on 'You said we did' boards in the outpatient waiting areas. Patient experience surveys showed a high level of satisfaction.
- Managers told us that patient feedback had been used to inform developments such as the new physiotherapy gym, increasing outpatient clinic capacity, developing evening services and improving car parking. We saw that staff valued patient feedback and the hospital employed volunteers who had previously been patients.
- The hospital did anonymised staff surveys twice a year. The data collection was completed nationally by the corporate team. Heads of departments received feedback on the results from their staff groups and completed action plans to address any concerns.
- The lead for training and development told us they worked with other hospitals within the company to support training delivery and gave an example of how they had worked with the training and development lead at another hospital within the company to support the delivery of children acute illness management training.

Good

Surgery

Learning, continuous improvement and innovation

- The lead for training and development told us they were able to access support and share information through the national clinical educators group. This group met every three months.
- The hospital held a sepsis awareness update during our inspection. This included a sepsis survivor attending to talk to staff about their experience.
- The hospital had recently introduced massive haemorrhage and sepsis equipment trolleys. This meant that staff had immediate access to all necessary equipment. The latest guidance had also been laminated and attached to the trolleys to provide a quick reference guide.
- The catering manager told us they had created an action plan to ensure compliance with the 2017 updated guidance on allergens.
- The catering team had a five-star local authority food hygiene rating.
- Staff we spoke with told us they felt the introduction of a champion for patients living with dementia was an improvement which had resulted in the development of more robust admission criteria and planning for vulnerable patient groups.
- The clinical lead told us the hospital was the first independent hospital to use 'Johns story' to promote the importance of care for people living with dementia.
- The hospital had also become part of the Safe Place scheme. This is a Humberside Police initiative active across the Humber region. Safe Place is a scheme to help vulnerable people to stay safe while out and about in their community. Safe Places provide a temporary safe haven, help and support for those in need. This includes people who have learning disabilities or difficulties, dementia or who need support or require assistance whilst in public. However, anyone who is feeling vulnerable, scared, confused or lost can also ask for help at a Safe Place. Users carry a Safe Place Card which they can show at the Safe Place if they need help.

Good

Services for children and young people

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

Information about the service

Children and young people's services were a small proportion of hospital activity. The main service was Surgery. Where arrangements were the same, we have reported findings in the Surgery section.

Summary of findings

Our rating for children and young people's services improved. At our last inspection we rated services for children and young people as requires improvement. At this inspection we rated this service as good because it was safe, effective, caring, responsive and well-led.

Since our last inspection, the hospital had improved the environment where children were cared for and strengthened the arrangements for monitoring patient outcome and performance data.

Good

Services for children and young people

Are services for children and young people safe?

Good

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

Mandatory training

- For our main findings please refer to the surgery report.
- The standard modules for mandatory training at Spire Hull and East Riding hospital included training in safeguarding children.
- We reviewed mandatory training information for the children's service with the hospital clinical lead. We saw that contracted staff were up to date with mandatory training, in all except one module. We saw that some bank staff were on maternity leave at the time of inspection. However, two bank staff who had started at the end of 2017, had only completed three modules each and managers told us this was because they were relatively new to the organisation.

Safeguarding

- For our main findings please refer to the surgery report.
- The Spire Healthcare Limited procedure for safeguarding children and young people in Spire Healthcare, issued June 2017, review date 2020, provided staff with guidance about safeguarding children and young people. The procedure followed relevant national legislation and guidance, for example the Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children published in 2018. It also included relevant and current information about female genital mutilation (FGM), child abduction, child sexual exploitation (CSE) and human slavery and trafficking. The policy contained relevant guidance about the national PREVENT strategy. PREVENT is part of the government's counter terrorism strategy.
- All consultants at Spire Hull and East Riding Hospital, who wished to have practicing privileges to deliver care and treatment to children and young people were required by the hospital to complete level three safeguarding children and young people training. All registered children's nurses (including bank and agency registered children's nurses) were required by the hospital to have completed level three safeguarding children's and young people's training. The resident medical officer (RMO) was required by the hospital to have completed level three safeguarding children and young people's training.
- The hospital used a dashboard of performance indicators to monitor performance of the children and young people's service. This showed that 100% of consultants who treated children and young people were up to date with level three training in safeguarding. It also showed that 83% of staff employed by the hospital had completed level two training (quarter two 2018) and 67% of staff had completed level three training (2017 scorecard).
- Records provided by the hospital indicated that all registered children's nurses who worked at the hospital including bank registered children's nurses, had completed level three safeguarding training. The clinical governance quarterly reports (quarter one and quarter two 2018) noted that the RMO had completed level three safeguarding children and young people training. Diagnostics staff told us all radiographers had completed level three training and health care assistants completed level two.
- A list of all medical staff with practicing privileges for the hospital and who had completed level three safeguarding children and young people's training was held by the governance lead.
- The children safeguarding lead for the hospital was the clinical lead. One of the consultants with practising privileges at the hospital was the named children and young people's safeguarding lead doctor. The CYP lead nurse was the safeguarding champion and had completed level four safeguarding children and young people's training. All staff we spoke with knew who the safeguarding lead was and said they would contact the CYP lead nurse in the first instance for advice if they had any concerns.
- Staff we spoke with demonstrated an understanding about safeguarding children and young people processes. A safeguarding information poster was displayed in all clinical areas with the photo and contact details of the safeguarding lead and information about the actions they must take in the event of a safeguarding concerns.
- We saw posters and a children's information and education leaflet; 'Where to find help for children and young people' was available which included

explanations helpline numbers in relation to FGM, CSE, modern day slavery, child and adolescent mental health services(CAMHS) and domestic violence, in the children's area on the ward. There was also a leaflet outlining the key principles of the Spire adult and children's safeguarding strategy.

- Staff completed a safeguarding children's admission checklist as part of their care pathway. This included identifying if there were any active safeguarding concerns about the child or identification of any risk factors that could indicate safeguarding concerns. Any potential restricted access visitors were also recorded in the care pathway.
- Spire Healthcare Limited policy required all children to be chaperoned by their parent or a registered children's nurse at all times during their admission.
- There was a local emergency procedure which set out action staff should take in the event of a missing child and staff were aware of the process to follow.
- There was a local procedure which set out what action staff should take if a child was not brought to an appointment and we saw an example of where this had been followed.
- The service had made one safeguarding referral in 2018 and we saw this had been completed and reported as an incident, in line with Spire policy.
- The CYP lead contributed to the East Riding Safeguarding Steering Group.

Cleanliness, infection control and hygiene

- For our main findings please refer to the surgery report.
- At our inspection in 2015, paediatric nurses we spoke with told us families were encouraged to bring in bedding and toys from home for children and young people undergoing surgery. We were concerned that this could present an infection control risk.
- At this inspection, we saw processes were in place for infection prevention and control. The CYP service brochure encouraged families to bring in a child's own cup or feeder and toys from home, however staff told us cups and feeders could be disinfected and children's bedding was provided by the hospital.
- The hospital provided toys for children to play with on the ward and in outpatient waiting areas. Toys we looked at were visibly clean. We saw staff signed daily checks lists to evidence they had cleaned the toys. Alternatively, some toys and activity books were single-use; given to children as a gift which they took home at the at the end of their visit.
- We saw that some fabric parts of the new wall-mounted interactive toys in waiting areas had been identified as not compliant with infection and prevention control requirements. Staff told us these elements had been removed and returned to the manufacturer for a solution.
- We saw hand gel dispensers available on the children's area of the ward and we saw child height gel dispensers in waiting areas.
- Staff carried out infection control risk assessments on all children and young people as part of their preadmission assessment process. This included detail about any recent illnesses, hospital admissions and childhood illnesses, and whether childhood immunisations were up to date.
- At our inspection in 2015, there were gaps in assessing and auditing of infection prevention and control procedures such as observational hand hygiene audits.
- At this inspection, we saw the service carried out hand hygiene audits to monitor CYP staff compliance with the hand hygiene policy. The hospital provided an example of a recent observational hand hygiene audit (Sept 2018), which showed 100% compliance with the hand hygiene policy by the staff member observed.
- Staff used an infection and prevention audit tool specifically for children and young people's services. This audit tool assessed hand hygiene facilities, the general environment, the patient's immediate environment and bed space, isolation processes, dirty utility, waste disposal, sharps safety, storage areas, clean utility and treatment room, equipment and clinical practices. We reviewed completed audits which indicated 100% compliance had been achieved in all areas at this site in February 2018 and in November 2017 (before the children's ward area had opened).

Environment and equipment

- For our main findings please refer to the surgery report.
- At our inspection in 2015, the hospital had not identified or sufficiently mitigated some of the risks the environment posed to children and young people. At that time there was no dedicated children's inpatient area or separate waiting areas for children in the

outpatient's department. Children were accommodated in side rooms on the adult ward and assessments did not identify all risks posed to children here, for example ligature risks from window blind cords.

- At this inspection, we saw the hospital had made changes to the environment children and young people were cared for and treated in and assessed risks to children and young people and took action to mitigate them.
- A separate three bedded bay at the end of the adult ward was designated as children and young people's accommodation and had opened in the week of our inspection. The ward area was of a sufficient size to accommodate any parents who wished to remain in the hospital overnight with their child. Staff told us an individual side room could also be made available, although this was currently unavailable due to ongoing refurbishment work in another department. Prior to the dedicated ward area opening, staff would set up side rooms for children and young people as required, using age-appropriate bedding and toys.
- Staff carried out risk assessments of all environments where children were cared for, including outpatients, radiology and physiotherapy departments. The hospital had mitigated against some of the risks identified during the last inspection by creating a specific children's ward area.
- On the children's ward, we observed that window blinds and a telephone cord in the children's ward area and an emergency cord in the bathroom, presented a potential risk to children. The potential risk from inadequate bathroom facilities had been identified and logged on the CYP risk register. The potential risks on the ward area had been identified by the service and work was underway during inspection to address these; managers told us the window blind cords had been cut to remove the risks where possible and that alternative blinds, frosted panels and a cordless phone were on order, to further reduce the risks. Staff told us the risks were mitigated because children would always be supervised by either a parent / guardian or a registered children's nurse.
- During this inspection, we observed neither the newly opened children's ward or the adult ward kitchen nearby were secured. Staff told us a security system was on order for the children's ward area and that work had been recently carried out on the kitchen and they were unsure if this included a plan to include a lock. Staff told us the risks were mitigated by child patients being accompanied by a parent or guardian or registered children's nurse at all times and that the hospital also had a procedure in place for a missing child. This did not take into account a risk to children who may be visiting the hospital, for example from the open kitchen area. During inspection, we witnessed a collision between a trolley returning from theatre and a member of staff coming out of the kitchen onto the ward corridor, which highlighted a potential risk from spillage of hot drinks or food. We reviewed the hospital incident log but did not see this incident or similar ones logged.
- In the theatre recovery area, one of the four bays was used for children. . Usually children's listing times meant they were treated first, We observed there were some occasions when children were in the recovery area at the same time as adult patients.
- The diagnostics department saw low numbers of children, however there was a calming mural on the wall in the MRI room. The CT room had ceiling tiles with illuminated cheerful pictures and the equipment allowed for a patient to go into the scanner feet first, which was designed to reduce the child feeling claustrophobic.
- In waiting areas, the hospital had introduced some wall-mounted play equipment, to indicate areas for children. On the main hospital site, this was to the side of the main waiting area, and next to the hot drinks machine. There were no chairs for parents / guardians in this area as it was part of the main thoroughfare into the hospital. At the Lowfield's building the waiting area was away from the main entrance route and there were seats and toys together. However, it was not a designated area for children and so adults sometimes sat there instead, which meant families used another part of the main waiting area away from the toys.
- We saw there were toys and activity books provided for younger children. Staff told us older children and teenagers preferred to use their mobile phone or electronic devices while waiting, however we did not see any information displayed about how to access the hospital Wi-Fi network, while waiting.
- There was dedicated children's emergency and resuscitation equipment on the ward and in the outpatient department at the main building and at Lowfield's. There was a paediatric emergency transfer bag on the ward. We saw that staff completed weekly

and daily checks and that tamper-proof seals were used to secure equipment. The resuscitation lead completed a bi-monthly audit of the trolleys at all sites and took action as required.

- There was separate paediatric emergency equipment in the theatre suite and recovery area. Records showed staff checked this equipment daily before and after children underwent treatment in the theatre suite. We saw all equipment was in date and there was age appropriate equipment, for example different sized airways.

Assessing and responding to patient risk

- For our main findings please refer to the surgery report.
- The service considered and took actions to lessen risks to children and young people.
- The procedure for the care of children and young people in Spire Healthcare (issue date April 2017, next review April 2021), set out the safe and agreed criteria for the admission of children to the hospital, which included ensuring only minor procedures were carried out at the hospital. The procedure took account of national guidance from the Royal Colleges and the National Institute for Health and Care Excellence (NICE). The hospital only admitted children from three years old upwards for interventional day case or inpatient procedures and from 12 months old, for outpatient medical appointments. The consultant was personally responsible for assessing children for suitability, working with the CYP team.
- The CYP lead nurse reviewed all bookings for under 18s and all children and young people undergoing any procedure in the hospital, either with general or local anaesthetic, attended a pre-assessment clinic. All inpatient paediatric admissions were authorised by the matron and would be declined if not appropriate, for example a 16-year-old booked for a rhinoplasty had not been authorised as there was no evidence of medical need.
- The preadmission assessment document was comprehensive and supported staff to identify and mitigate against any issues, health, social or emotional, that had the potential to increase the risks factors to the child during their admission.
- We saw from patient records that the assessment was completed by a registered children nurse and gave the opportunity for a visual assessment of the patient as well as discussing their forthcoming treatment and obtaining relevant past medical history. Parents and guardians were strongly encouraged to bring their child for a face to face pre-assessment and staff arranged appointments to make this convenient for families.
- There was always a registered children's nurse on duty when there was a child under the age of 16 was admitted to the hospital. If there was more than one child admitted or if the nurse on duty did not have European Paediatric Advanced Life Support (EPALS), there were two registered children's nurses on duty. Staff rotas confirmed this happened.
- The children and young people's (CYP) service provided a 24-hour telephone line that children and their parents could contact post discharge if they had any concerns about the recovery of their child. Families could also send a text message to the same number.
- The hospital had a local policy to help staff identify post-discharge complications which identified how to respond if a parent or carer contacted the duty nurse for advice, for example to call 999 or contact the paediatric consultant.
- In the hospital, children and young people's health and wellbeing was monitored using the nationally recognised paediatric early warning system (PEWS). This identified if a child or young person was at risk of deteriorating and identified when a child or young person's condition needed to be escalated to a medical practitioner.
- The hospital used a clinical score card to monitor performance of the children and young people's service. This showed that compliance with PEWS record-keeping ranged from 90% to 100% from July 2017 to June 2018, with an average of 96% against a target of 95%. We saw that PEWS scores were calculated and escalated appropriately in the records we reviewed
- The hospital used the National Patient Safety Agency (NPSA) adapted five safer steps to surgery. This is a check list used before, during and after surgery to reduce the risk of mistakes occurring during surgery. Our review of eight patient records showed this safety check was included and completed in the patient pathway records.
- Staff used Spire Healthcare Limited policy for the management of sepsis (issued March 2018, next review March 2021), for guidance in the event of suspected sepsis. This included guidance about the identification and management of sepsis in children and young people. The children's service used the nationally

recognised paediatric sepsis six pathway for children aged five and under and for children aged five to 11 years to support the management and treatment of children with suspected sepsis. For children over the age of 11 the adult's sepsis six pathway was used. There had been no incidents of sepsis in children in the 12 months preceding the inspection of the service.

- In the event of a child's condition deteriorating and requiring critical care facilities, children and young people were transferred to NHS paediatric critical care facilities using the regional paediatric critical care retrieval service. The hospital had a current three-year service level agreement in place with the local NHS trust for this, dated February 2018. Information from the hospital indicated this included consultant paediatric support, available 24 hrs a day
- The hospital also had a service level agreement in place with the paediatric critical care retrieval service (EMBRACE) dated January 2017, however we found this was not current and had been due for review in January 2018. The CYP lead nurse also showed us evidence of action taken to chase a renewed agreement in June 2018 and assurance from the NHS trust that a service would still be provided if required.
- Staff told us the resuscitation lead facilitated four emergency scenarios per year. We saw that training scenarios relating to children and young people's emergencies had been completed at the main hospital, at Lowfield's and at Spire Hesslewood since June 2017.
- The procedure for the Care of Children and Young People in Spire Healthcare included requirements for resuscitation training. The policy included the training requirements for different staff groups employed at the hospital. All registered children nurses (RCN), recovery staff and the resident medical officer (RMO) were required to have successfully completed either the EPALS or the Advanced Paediatric Life Support (APLS) course. RCN were required to have completed paediatric AIMS with annual PILS update. Other clinical staff were required to have successfully completed the Paediatric Intermediate Life Support (PILS) course.
- Spire minimum resuscitation training requirements for CYP services recommended that two members of staff are trained in EPALs, four members of staff are trained in PILS. The policy states that when treating children aged three to 12 years old, an RMO with PALS or EPALS will be provided. Information provided by the hospital indicated that nine of 12 staff had completed EPALS training and 39 of 64 staff had completed PILS. The CYP clinical score card showed that 100% of consultants had met resuscitation training requirements (quarter two 2018).
- The clinical governance quarterly report (quarter two 2018) noted that all RMO's who work at the hospital had completed EPALS training and that minimum requirements were met. However, one RMO did not have up to date EPALS training. This had been appropriately logged as a risk by the CYP lead and discussed at the clinical governance meeting. The risk was mitigated by; ensuring no children were booked as inpatients when this RMO was working until training was completed (booked for October 2018). Staff also completed a paediatric inpatient risk register which included a check to ensure appropriate staff, including an RMO with EPALS, was available on the day of admission.

Nurse staffing

- For our main findings please refer to the surgery report.
- The service had enough nursing staff with the right qualifications, skills, training and experience to keep children and young people safe from avoidable harm and to provide the right care and treatment.
- At the previous inspection in 2015, the CYP lead nurse employed at that time did not work full time at Spire Hull and East Riding hospital. This meant there was not always a registered children's nurse identified and available with responsibility and accountability for the whole of the child's pathway.
- Following that inspection, the hospital reviewed their provision of children and young people's services and adopted a family-nurse model. The local lead nurse for CYP now had allocated accountability for children's services across the hospital, including outpatient services and radiology services and services delivered at Spire Hesslewood. This was in line with Royal College of Nursing guidance on defining staffing levels for children and young people's services. This stated there must be a registered children's nurse identified and available with responsibility and accountability for the whole of the child's pathway, including their pathway through outpatient departments. The local lead nurse for CYP was supported by a national lead nurse role for children and young people's services at Spire Healthcare Limited, who also had operational responsibility at another Spire location.

- At this inspection, we found the staffing model was designed to be agile. There was one contracted employee leading the children's team (12 hours per week) supported by a second part-time contracted nurse (1 day per week) and five registered children's nurses (RCNs) who were employed as regular bank workers.
- The service intentionally recruited bank staff who also held other areas of employment in the acute children and young people sector, usually with the NHS. This provided a workforce with a larger skill set and specialist skills from their other areas of employment and meant the service did not work in isolation. Staff had been chosen to match skills to the needs of children and families to meet the growing needs of the service. For example, two registered children's nurses who already worked in theatres could support the pre-assessment clinics, a school nurse who could support the hospital's work with children looked-after and; a nurse with expertise in supporting young people in transition between child and adult services. All RCNs worked at Spire Hull and East Riding and at Spire Hesslewood, as required. The service had recently recruited to the bank, recognising that the CYP lead nurse needed additional nursing support to deliver a safe service, with regular bank staff on maternity leave and an expanding service.
- The Royal College of Nursing guidance details that 'at all times there should be a minimum of one registered children's nurse in the recovery area' and when children were being recovered from general, epidural or spinal anaesthesia there should be two registered children's nurses on duty. Two theatre nurses were registered children's nurses and worked with the registered children nurse on duty to care for the child in the recovery area. If there was more than one child admitted to the hospital at a time, two registered children's nurses were rostered. This ensured a children's registered nurse was always present in the recovery area to support the recovery staff caring for the child immediately postoperatively.
- The Spire Healthcare Limited national CYP lead told us the service had revised its booking processes so all under 18 bookings, were now flagged to the lead nurse weekly, to ensure that a registered children's nurse was on duty for the full admission of a child under the age of 16 and appropriate staffing was in place. The hospital CYP lead nurse told us they reviewed all bookings for under 18s, including outpatients; that children and young people would be rebooked if appropriate staff were not available, and that agency nurses were not used at this location.
- There was a risk-based approach to nurse staffing for young people aged 16 to 18. Preadmission assessment identified whether the young person was appropriate to follow the adult pathway. This meant they would be cared for by adult nurses who had completed relevant competency assessments or registered children's nurses. This process included considering the wishes of the young person.
- Staff said they had access to an external play therapist employed by Spire Healthcare Limited, who they could refer to for additional support, for example for a child assessed as being highly anxious about their hospital admission during the preadmission assessment process. The lead CYP nurse also had experience in this area.

Medical staffing

- For our main findings please refer to the surgery report.
- The service had processes in place to ensure medical staff had the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Each child was admitted to the hospital under the care of a named consultant with paediatric experience. The hospital required consultants to be available to attend to the child within 30 minutes of being called, which met the recommendations set out by the Association of Independent Healthcare Organisations.
- Information provided by the hospital showed there were 35 consultant surgeons and seven anaesthetists with paediatric practicing privileges listed on the paediatric register (quarter two June 2018). Staff told us the booking system would now prevent appointments being booked if the consultant was not listed on the paediatric register.
- Consultants were required to complete annual paediatric basic life support training (PBLS) and safeguarding children level three training. If these were not completed, the consultant was suspended from carrying out treatment on children until they evidenced they had completed the training. We saw examples of medical staff being temporarily suspended from the paediatric register if this were the case.

Good

Services for children and young people

- All consultant surgeons, paediatricians and anaesthetists had to complete an application for paediatric admitting rights. This considered their experience in carrying out named procedures for children of a specific age range. This information was used by the hospital management team to determine whether the person had the required skills and experience to carry out paediatric treatments at the hospital. Medical staff who could not demonstrate they had the relevant skills were not granted practicing privileges.
- The hospital policy for the care of children and young people stated that to be considered for practising privileges for children under three years old, consultant surgeons and physicians would need to provide evidence they were providing services for children at a specialist NHS unit.
- The RMO was required to provide evidence of four to six months paediatric experience and evidence of annual updates of EPALS. Staff completed a paediatric inpatient risk register which included a check to ensure appropriate staff, including an RMO with EPALS, were available when children were admitted.
- The service had 24-hour access to a consultant paediatrician for advice and support at the local NHS trust.

Records

- For our main findings please refer to the surgery report.
- Staff kept detailed records of patients' care and treatment.
- The eight inpatient records we reviewed (care pathways) showed that nursing staff completed the relevant assessments and child's details on every page. The entries were legible and signed and dated by the member of staff who completed the entry.
- However, we noted that medical staff did not record their grade and GMC number in any of the patient records we reviewed, which does not meet professional guidelines. We reviewed eight prescription charts and found that entries in two records were not always legible.
- We saw that families were given written discharge information following an admission, which included a letter to give to the child's GP.

Medicines

- For our main findings please refer to the surgery report.
- We reviewed eight patient records and prescription cards. Medicines prescribed on the prescription charts were dated and signed by the prescriber. We saw that staff recorded children and young people's allergies in their records and on their medicine prescription chart. We saw that age and weight were also recorded. However, we found entries in two records which were not legible.
- As part of the pre-admission process, staff completed pregnancy tests on girls aged twelve or over, to reduce associated risks.There was a specific policy in place for pregnancy testing of children and young people which gave guidance and information for staff to follow and made specific mention of the dermatology medicines where pregnancy testing was important.

Incidents

- For our main findings please refer to the surgery report.
- The service had a good track record regarding incidents. There had been no serious incidents and no never events involving children.
- There were two no harm clinical incidents reported from July to December 2017 and three clinical incidents reported for children and young people's services from January 2018 to June 2018. Two were unplanned returns to theatre during the same surgical admission and one was a sample labelling error. The hospital reported the incidents resulted in no harm for the children or young people involved.
- Staff we spoke with, who cared for children and young people, had a clear understanding about incident reporting. They knew how to report incidents and the types of incident that needed to be reported. Staff said they received feedback for reported incidents and learning was shared.
- The hospital CYP lead nurse and the national Spire Healthcare CYP lead nurse received and reviewed all incidents involving anyone under 18 years old. This had started in April 2018, following learning from an internal clinical review (February 2018).We saw that incidents were recorded in the CYP quarterly clinical governance report which was submitted to the hospital clinical governance meeting.

Safety Thermometer

- For our main findings please refer to the surgery report.
- The Children and Young People's Services Safety Thermometer is a national tool that has been designed

to measure commonly occurring harms in people that engage with children and young people's services. The tool focusses on: deterioration, IV lines, pain and skin integrity.

- Spire Hull and East Riding hospital had begun to contribute to the safety thermometer on a monthly basis and this was reviewed at the clinical governance meeting. No harms were identified. We saw information displayed in waiting areas on the hospital's performance against the children's safety thermometer.
- The hospital also used the CYP clinical score card to record monitoring of safety issues such as pain management, temperature recording, compliance with PEWS recording (management of deteriorating patient) and unplanned returns to theatre.

Are services for children and young people effective?

Good

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

Evidence-based care and treatment

- For our main findings please refer to the surgery report.
- At our inspection in 2015, there was very little evidence provided by the hospital to indicate whether they used the National Institute for Health and Care Excellence (NICE) or other specific national guidance for children's services and no specific audits of children and young people's services were carried out.
- At this inspection, we saw that policies reflected national guidance and specific children and young people's service audits had been introduced to drive service improvement.
- Children and young people's care and treatment took account of national guidance. We saw that most policies and procedures took account of national guidance. For example, the resuscitation policy referenced the Resuscitation Council Guidelines 2015 and the procedure for the care of Children and Young People in Spire Healthcare policy included references to the United Nations Convention on the Rights of the Child 1989 and guidance from the Royal College of Nursing.
- The hospital provided a consultant led service for gender reassignment and staff used national guidance to support this pathway such as Interim Gender Dysphoria Protocol and Service Guideline 2013/2014 (NHS England) and Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (the World Professional Association for Transgender Health).
- There was a national lead for children and young people's services at Spire Healthcare Limited, who was leading a review of national policies, with the aim to incorporate CYP into central policies, as they were reviewed. They also supported the local CYP lead and completed twice annual clinical reviews of the CYP service at Spire Hull and East Riding.
- At the previous inspection the service did not have an identified audit plan in place specifically for paediatric care at the time of our inspection, which meant that learning from formal clinical audits, benchmarking or tracking clinical outcomes did not take place.
- At this current inspection, we found there was a planned audit programme, the results of which fed into the paediatric clinical score card. The audit programme included audits of documentation, health and safety, infection control and safeguarding and included repeated audits to identify and monitor improvements in the delivery of the service. The paediatric clinical score card was compared Spire Hull and East Riding hospital's performance against those of other Spire Healthcare hospitals that delivered children's services. The use of the clinical score card meant the service was now able to learn from formal clinical audits and benchmarking to improve the service and ensure the service was delivered in line with national guidance.
- The clinical score card monitored a range of indicators including; completion of consent forms and PEWS records, monitoring of theatre starve times, patient temperatures and patients' pain. Completion of risk assessments including for safeguarding, for inpatients aged 16 to18 years and for all interventional procedures in outpatients, were also monitored.For the period 1 Jan 2018 to 30 June 2018 (quarter one and two), the service met all targets for every indicator and was 100% compliant on all except two indicators; temperature recording compliance on PEWS (in theatre and recovery) (95% against a target of 90%); and the percentage of staff compliant with level two safeguarding training (83% against a target of 50 or more %).
- We saw that actions were identified where performance was below 100% even where it had met the target. For example, when the service was 91% compliant with

recording patient temperatures during the intraoperative phase (against a plan of 90%) in quarter one, the CYP lead developed a plan of action with theatre staff and performance improved to 95% in the following quarter.

- We noted that the service did not currently score itself against the indicator; 'Fully completed risk assessment for all interventional procedures in OPD present in patient record'. However, we saw that a risk assessment form was available for children and young people coming to the hospital for minor operations, interventional procedures in outpatients and radiology.
- Information from the hospital indicated that a paediatric anaesthetic audit, CYP health and safety audit and infection control audits were also completed.
- The hospital had signed up to the 'You're Welcome' accreditation scheme for services for children and young people. The CYP lead had completed a self-assessment against the 'You're Welcome' criteria within the last 12 months. This showed the hospital achieved rating of 'getting there', against the standard. Almost all the essential criteria were met, however areas for improvement were identified including: the management of information for children and young people, specifically annual review and updating and providing information in different languages. Staff identified action was needed to ensure information material was available in other languages and to put systems in place to manage this. There was also an action to ensure that formal clinical supervision took place, although timescales and accountability were not yet identified for this.

Nutrition and hydration

- For our main findings please refer to the surgery report.
- At our inspection in 2015, in all of the patient records we reviewed, we saw all food and fluid charts were incomplete. For example, four out of five had no output entries and in all five, staff had not totalled up the input figures. This meant there was a risk of inadequate hydration as it was not possible to confirm what the child's fluid intake and output had been.
- At this inspection, we saw that prompts for staff to record entries on the fluid balance sheet were incorporated into the CYP day case and inpatient pathway documentation which staff used to plan and deliver care. We saw that the care pathways we reviewed were completed appropriately.
- Children, young people and their parents or guardians were advised about pre-surgery fasting (that is omitting food and fluids except water before an operation) times during the preadmission assessment process. The service followed the Royal College of Anaesthetists guidance about preoperative fasting to ensure children and young people fasted for the safest minimal time possible. The hospital audited whether CYP theatre starve times were within guidelines and scored 100% compliance from January to June 2018.
- The hospital local policy for the care of children and young people recommended that children were operated on first on the operating lists to ensure minimal fasting times and maximum recovery time whilst the consultant was on site. We observed that children were usually scheduled first on operating lists.
- A children's menu was available and child-friendly items, for example small sandwiches, could be provided although we did not see this during inspection. Children and young people had access to a choice of refreshments.
- Staff said they could refer either to a dietician at the local NHS trust, or to a dietician employed by Spire Healthcare Limited, for additional support.

Pain relief

- For our main findings please refer to the surgery report.
- We saw that care pathways included an assessment of the child's pain on admission and during their admission. We saw from the eight records we reviewed and the procedure we observed, that staff discussed management of pain after the procedure with the child and parent at the time of admission and gave parents written information about pain relief on discharge.
- Staff also used the PEWS documentation, which included an appropriate pain tool, although we did not see this used, in the records we reviewed. We saw that for two patients, no pain tool was used and no regular or as needed pain relief was prescribed.
- The hospital audited whether patient's pain scores were recorded with every set of observations and the service scored 100% compliance from January to June 2018.

Patient outcomes

- For our main findings please refer to the surgery report.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them.

Good

Services for children and young people

- At our inspection in 2015, staff told us patient outcomes were good; however, we did not see any evidence to show that patient outcomes for children and young people's services at the hospital were routinely monitored. At that time, the hospital did not measure children and young peoples' outcomes separately, which meant they could not demonstrate how effective the children's and young people's service was at the hospital.
- At this inspection, we saw the hospital now measured outcomes for children and young people using a planned audit programme and the paediatric clinical score card. Results were reported in quarterly governance reports prepared by the lead nurse.
- Data from the paediatric scorecard showed that there had been no known surgical site infections, no avoidable cancellations on the day of surgery, no unplanned readmissions and no unplanned transfers to other hospitals in the period January to June 2018. There were two unplanned returns to theatre during the same surgical admission, for the same period. This was for adjustments and was comparable with other Spire locations.
- The service did not take part in any external audits and staff explained this was mainly due to low numbers of children and young people seen.

Competent staff

- For our main findings please refer to the surgery report.
- At our inspection in 2015, the children and young people's service cared for low numbers of patients and had low numbers of nursing staff; these staff-maintained competencies in their roles within other organisations, usually within the NHS, which also employed them.
- At this inspection, numbers of young people had increased and a similar model was in place, however all staff caring for children were also required to have completed paediatric competencies and have up to date training in safeguarding level three and life support, appropriate to their role. The clinical lead confirmed that no staff would look after an under 18-year-old without paediatric competencies.
- An internal clinical review (February 2018) had highlighted; incomplete CYP competencies in outpatients and diagnostics.However, information provided by the hospital, at the time of our inspection, demonstrated improvement. All CYP staff (100%) had completed the competencies. In addition to this some diagnostics and pharmacy staff had undertaken the competencies despite this not being a requirement of their role. In total we found 56% of all staff who did not require the competencies had undertaken them. This included 92% of outpatients staff, 81% of physio staff, 45% of theatres staff and 19% of ward staff.
- Staff told us that the majority of diagnostics appointments were for ultrasound scans and these were led by a radiologist who was a paediatric specialist.
- At our inspection in 2015, when we asked about phlebotomy for children and young people the matron told us, the number of children and young people needing blood tests on-site was low. The matron told us three or four phlebotomy staff were booked to attend a paediatric phlebotomy course.
- At this inspection, we found the Spire Healthcare Limited procedure for the care of children and young people defined that only staff with specific paediatric venepuncture competencies could take blood from children and young people in the outpatient's department. The hospital CYP lead nurse confirmed that only registered children's nurses with these competencies took blood.
- The hospital clinical lead was responsible for completing an appraisal with the CYP lead nurse twice a year. Although appraisals were not formally required, the CYP lead completed informal appraisals with bank staff. Some bank staff were on maternity leave at the time of inspection and some were too new to the organisation to have yet had an appraisal but reported positive induction discussions about development.
- A self-assessment against the 'You're Welcome' criteria had identified clinical supervision as an area for improvement. An action was identified to ensure that formal clinical supervision took place, although timescales and accountability were not yet identified for this.

Multidisciplinary working

- For our main findings please refer to the surgery report.
- The children's nurses took full responsibility for communicating the needs of all inpatient children under their care with the general nursing staff, medical staff and other healthcare professionals as appropriate.
- All staff we spoke with told us staff in the hospital worked as a team to support children and young people in hospital. For example, diagnostics staff reported a

very positive relationship with the CYP lead. They were always informed of paediatric patients and told us a specialist children's nurse would come to the X-ray department to support patients and families.
- All registered children's nurses working at the hospital were also working in other roles, for example in the local NHS or the local authority, which meant the service could easily access a variety of skills and expertise.
- An internal clinical review in February 2018 identified that discharge processes could be improved to ensure that schools and health visitors were also updated regarding treatment provided. We saw that prompts for staff to refer to community or school nurses or other agencies, as required, were already incorporated into the CYP day case and inpatient pathway documentation.

Seven-day services

- For our main findings please refer to the surgery report.
- All admissions for children and young people were planned, to ensure there was access to diagnostic services when required.

Health promotion

- For our main findings please refer to the surgery report.
- Although there was no formal health promotion programme for children and young people admitted as inpatients, staff told us they took opportunity to discuss healthy lifestyles where appropriate with children, young people and their parents.
- We saw a children's information and education leaflet; 'Helping to keep you safe from infection' which included hand hygiene tips and infection prevention measures, on display in the children's ward area and waiting area.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- For our main findings please refer to the surgery report.
- Consent was obtained from children and young people.
- Staff used the Spire Healthcare Limited consent policy (Jan 2016, review Jan 2019) which included guidance for staff on consent and children and young people including parental responsibility and Gillick competency and consent for 16 and 17-year olds. Staff used a specific consent form for children and young people. Staff we spoke with were aware of their legal responsibilities.
- Patient records we viewed and the procedure we observed, showed consent for procedures was obtained. We saw there was space on the form for children to sign if they were able to consent to their treatment.
- The hospital audited whether consent forms were fully completed, and the service scored 100% compliance from January to June 2018.

Are services for children and young people caring?

Good

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

Compassionate care

- For our main findings please refer to the surgery report.
- We observed caring interactions between staff and children and young people and their families at all times.
- Staff supported children to reduce anxiety about coming to hospital in a variety of ways.
- Longer appointment times were allocated for children in the diagnostics department and to reduce fear, staff would x-ray the child's teddy bear and show them the x-ray picture, before x-raying the child. Children and their parents could come and have a look around, prior to their scan. Children's nurses recommended appropriate video clips and online resources to familiarise themselves with the process.
- Staff, including housekeeping team, told us that they were often introduced to children and families who came in for pre-assessment, which helped to put them at ease, as children would recognise them when they were admitted into hospital.
- The hospital used shortest fasting times as possible on the day of the procedure and allowed children (and parents) to wear their own clothes in theatre.
- Open visiting times were promoted, and parents/carers could stay overnight with children where required.
- Staff told us they maintained dignity of patients, for example weighing them in the privacy of a consulting room.

Emotional support

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

Good

Services for children and young people

- Staff demonstrated a sensitive and supportive attitude to children and young people, parents and carers.
- Physical and emotional needs of children had been considered in the design of the children's ward area. The décor was bright and cheerful. A variety of toys, that also encouraged child development and supported distraction therapy, were available for children to play with.
- The hospital provided a consultant led service to support young people undergoing gender reassignment and received referrals from the national gender identity service. The CYP lead demonstrated compassionate leadership and a clear understanding of the emotional needs of young people undergoing gender transition. For example, using appropriate pronouns and language to describe procedures, the importance of confidentiality, and the role of the registered children's nurse and child and adolescent mental health service (CAMHS) in supporting young people to maintain supportive friendship networks through the process.
- The CYP lead described supporting a child with a needle phobia by inviting them to visit the pathology lab, wear a child-sized white coat and meet the scientists to understand what happens to their blood samples, to reduce anxiety about the process.

Understanding and involvement of patients and those close to them

- For our main findings please refer to the surgery report.
- There was evidence of documented discussions with children and families in all the patient records we reviewed. Families told us medical staff used words their child could understand to explain what was happening. We observed good communication and positive interactions between staff and children and families and staff also listened to concerns.
- We observed that staff gave clear help and advice to children and parents, to help them understand what was happening. For example, encouraging the child to understand why it was important to eat after a procedure and giving advice to parents about pain relief and resuming daily activities. Written information was also provided.
- We found there were leaflets suitable for children to understand. Children's nurses also recommended appropriate video clips and emailed online resources to families to help familiarise themselves with the process.
- There was an information leaflet; 'Your visit to hospital – a guide to coming into hospital' which the bookings team sent out to families. This included information on what to expect and how to prepare. Pre-operative information was available to children and their families in a digital and booklet format.
- Other information leaflets were available including what children could do to prevent infections and posters and a children's safeguarding information and education leaflet. This included explanations and helpline numbers in relation to FGM, CSE, modern day slavery, CAMHS and domestic violence.

Are services for children and young people responsive?

Good

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

Service delivery to meet the needs of local people

- For our main findings please refer to the surgery report.
- The service planned and provided services in a way that met the needs of children and their families.
- Children and young people attended the hospital for planned surgical procedures, outpatient appointments, x-ray services and physiotherapy. Following national guidance, inpatient surgical services and outpatient physiotherapy services were only offered to children age three and above. All procedures were planned.
- Children and young people attended Spire Hull and East Riding hospital as privately funded, insured patients or as NHS patients. The hospital was also commissioned to provide health assessments for children and young people looked after by the local authority.
- At our inspection in 2015, there were no dedicated children's areas of the hospital. This meant children were seen and treated in the same areas as adults.
- At this inspection, we saw the hospital had recently reviewed its arrangements and made changes to improve the environment for children and young people. There was now a three bedded children's ward designed specifically to meet the needs of children and young people or alternatively a side room could be flexed to accommodate a child.

Good

Services for children and young people

- At our inspection in 2015, there were no separate areas for children and young people to wait and/or be seen in the outpatient's department. There were no toys available; when we asked about this, we were told colouring books and crayons were available on request.
- At this inspection, the service had identified and developed a space for children in the main hospital site waiting area and in the waiting area at Lowfield's. This space included toys and activity books suitable for different age groups.
- Volunteers worked in a variety of roles in the hospital, including supporting parents of children and young people, for example while waiting for the child to return from theatre, as agreed with the CYP lead.
- With a growing children's service, staff had recently moved to scheduled weekly pre-operative assessment clinics, to ensure every patient under 18 had a face to face assessment with a registered children's nurse.

Meeting people's individual needs

- For our main findings please refer to the surgery report.
- The service planned and provided a service that met the individual needs of children and young people. Staff used a holistic approach to develop individual care packages to support children, young people and their families.
- If parents wanted to stay with their child, a bed was made up for them next to the child's bed space. There were showering and toilet facilities on the ward for parents and their children to use. There was sufficient room in both the single room and the ward area, for parents to stay.
- The hospital provided toys for children to play with on the ward and in outpatient waiting areas. Some toys and activity books were single-use; given to children as a gift which they took home at the at the end of their visit.
- From July 2016, all organisations that provide NHS care must have fully implemented and conform to the Accessible Information Standard - to identify, record, flag, share and meet information or communication needs relating to a disability, impairment or sensory loss. We saw that communication needs, including a need relating to a disability or mental health issue, were considered in the pre-assessment process and this was then available to the children's nurse for follow-up appointments. Communication aids and picture boards were available. We saw notices at reception desks asking patients to advise staff if they had a disability communication need.
- The hospital offered access to translation services for patients where English was not their first language. The hospital had a local process to follow to access services as required through a national contract across the Spire Group.The process made it clear that family members could not be used as interpreters in line with best practice in any clinical matter.
- Spire Healthcare Limited consent policy gives advice for staff on when an interpreter is required and clearly notes that; 'it is not appropriate to use children under the age of 16 years and preferably not under 18 years to interpret for family members who do not speak English.'It was not clear whether this was for clinical matters and the provider advised this policy would be updated to make this clear.
- We saw no information available in different languages and staff had identified this as an area for improvement, following the 'You're Welcome' assessment. Staff knew how to obtain an interpreter as required and records showed that they were used.
- The service made adjustments and had reconfigured weekly outpatient clinics to better meet the needs of children and young people with particular needs relating to disability. For example, clinics for children with learning difficulties, ADHD and Asperger's were now scheduled at the quieter Lowfield's building and held on a Saturday morning. This recognised that a busy noisy late weeknight clinic at the main hospital building was not the best environment in which to make an effective assessment of these children and young people. Staff told us that the quieter environment had led to a much-improved patient journey and positive feedback from families.
- The CYP lead described how the service had taken a similar approach when planning medical assessments for looked after children. This was important because some children and young people had been exposed to traumatic experiences, especially those children seeking asylum and a quiet and streamlined clinic made the patient experience more tolerable for them.
- The child's individual needs were discussed during the preadmission assessment process and information was used by staff to plan individual care and treatment. The assessment considered communication needs and

contact with CAMHS or other mental health needs. This child-centred approach meant the service was able to admit children based on their needs who had complex needs, for example a learning disability, including those on the autistic spectrum. However, the hospital did not have facilities to support the care of children with high complex needs, therefore any referrals received would be passed to a more appropriate provider.

- If, during the preadmission assessment process, staff identified the service could not meet the child or young person needs, staff referred the child to alternative health care providers who could support the child and their parent. CYP gave an example where they had liaised with a child's GP or written a letter of referral to CAMHS to help secure appropriate support for a child or for a parent.

Access and flow

- For our main findings please refer to the surgery report.
- Children and young people could access the service when they needed it.
- At our inspection in 2015, feedback from parents was mixed about the timeliness of their child's procedures and parents told us they had waited a long time on the day of the operation or that it had been cancelled.
- At this inspection, we saw that children's procedures were booked at the beginning of theatre lists, which usually meant it was timely and children and young people could recover and return home the same day. We reviewed the paediatric admission register which confirmed this and spoke with staff who were flexible about coming in early to accommodate early lists.
- Data from the paediatric scorecard showed that there had been, no avoidable cancellations on the day of surgery, in the period January to June 2018.
- Although there was no formal monitoring about how long children had to wait for their operations on the day, starve time compliance was good and the service had not received any complaints related to the length of time children waited for surgery.
- Although there was no formal monitoring of referral to treatment times for children's services, staff told us they usually saw children within two weeks of referral or sooner if the child's condition was urgent or the parents were worried.
- One parent told us they had been able to speak to the consultant on two separate occasions in between outpatient appointments, which had been helpful to address their immediate concerns.
- Parents and children, we spoke with in outpatient waiting areas, told us they were usually seen on time for appointments and we observed this to be the case, with some patients being seen ahead of their allotted time.
- Staff reviewed outpatient waiting times for children and young people in January 2018 and found five out of six patients were seen within five to 19 minutes.
- Diagnostics staff told us that children and young people were allocated longer appointment times and they rarely had to wait to be seen.

Learning from complaints and concerns

- The service had received two complaints in the previous 12 months which had been responded to in a timely and appropriate way.
- Staff provided examples where they had made changes to practice in response to comments from parents of children and young people. This included introducing a dedicated email address and mobile telephone number for parents to contact the CYP nurse on duty with any questions, following some difficulties in contacting relevant staff. Staff told us feedback was positive as families liked that they could also send a text message to the same number.
- A comments book was available and feedback from children and families included in the quarterly governance report was very positive.

Are services for children and young people well-led?

Good

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

Leadership

- For our main findings please refer to the surgery report.
- Leaders of the children and young people's service had the right skills and abilities to run a service providing high quality sustainable care.
- The service was led by a registered children's nurse (CYP lead nurse). The CYP lead nurse reported to the clinical lead for the hospital. There was a lead paediatric

consultant, a lead paediatric anaesthetist and a team of surgical and anaesthetic consultants experienced in the surgical management of children and young people. The outpatients service for children and young people was based within the existing outpatients service and overseen by the CYP lead.

- An internal clinical review in February 2018 had noted that although the hospital had a CYP lead, they were not designated as head of department (HOD), as required for a standalone service by Spire Healthcare Limited policy. The review noted that representation at HOD level was important to ensure the hospital has a qualified paediatric representative at a level within the hospital to influence strategy and advise on any developments and how they may impact on CYP. We observed that the CYP lead managed on-call responsibilities as well as another role within the hospital and at the local NHS trust. They were supported by the CYP national Spire lead and attended the daily HODs safety huddle meeting with the hospital director when available. When they were unable to attend the huddle, an update was provided through the ward manager.

Vision and strategy

- For our main findings please refer to the surgery report.
- At our inspection in 2015, staff were unable to describe a vision or strategy for children's services within the hospital.
- At this inspection, staff we spoke with, understood the service aims to develop and increase the number of children and young people seen at the hospital. Staff appreciated that recent work to recruit a diverse skill mix within the CYP team and the new children's ward area, was central to this.
- The children and young people's lead had a vision for what they wanted to achieve which was supported by the Spire Healthcare Limited lead nurse for CYP.
- We noted that the internal clinical review in February 2018 highlighted that CYP does not feature as part of the hospital strategy display.

Culture

- For our main findings please refer to the surgery report.
- Leadership of the children and young people's service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- There was a positive culture across all staff in the delivery of children and young people's service. All staff spoke highly of the support they received from the children and young person's lead nurse.
- The lead nurse reported increasing engagement from senior leaders at Spire for CYP services. Both lead nurses noted that being heard was important for a growing service.
- The Spire Healthcare lead CYP nurse commented on the strength of the CYP lead in developing a flexible staff team, with a variety of skills and experience and believed the time was now right to expand and develop the children and young people's service.
- Whistleblowing posters were visible in staff areas and staff expressed confidence that they could speak to managers about any concerns they had about services or other staff.

Governance

- For our main findings please refer to the surgery report.
- At the previous inspection in 2015, governance processes did not support quality monitoring of the children and young people's service.
- At this inspection, we found governance of the children's and young people's service had been established, linked to the governance processes for the whole hospital. A CYP clinical score card had been introduced and the CYP lead reported on this quarterly to the hospital clinical governance meeting. The lead paediatrician represented the CYP service in the Medical Advisory Committee (MAC) meetings. There was a lead CYP anaesthetist who oversaw the anaesthetic services for children at the hospital, meeting the guidance on the provision of paediatric anaesthesia service 2015 published by the Royal College of Anaesthetists.
- The lead CYP nurse was fully engaged in the planning and development of the children and young people's services at the hospital. An annual steering group for children and young people's services was in development to guide the future development of the service. Volunteers worked in a variety of roles in the hospital, including supporting parents of children and young people, for example while waiting for the child to return from theatre, as agreed with the CYP lead. Staff explained there was a specific recruitment process in place for volunteers working in the hospital which included an application form, interview, references and an advanced DBS check. The minimum age for

volunteers was 18 years old and volunteers were asked to commit to 12 months service. Volunteers were required to complete level 1 safeguarding training and PREVENT training and received initial information about safeguarding and who to contact if they had a concern, during their induction period.

Managing risks, issues and performance

- For our main findings please refer to the surgery report.
- The service had effective systems for identifying risks and planning to eliminate or reduce risks.
- At our inspection in 2015, we did not find any evidence of audits, risk management or quality assurance for children and young people's services at the hospital. While audits of patient records took place, there were no specific CYP audits.
- At this inspection, we found there was a specific audit plan, clinical score card and risk register for the children and young people's service which were used to manage risks, monitor and improve performance and quality.
- The audit plan included specific audits of infection prevention and control and patient records for children and young people. Audit results fed into the clinical score card which compared performance with other Spire locations nationally.
- The management of the risks, issues and performance relating to children and young people was owned by the CYP service and managed by the CYP lead nurse. The CYP lead nurse had full oversight of the service including all risks to the service and reviewed all incidents involving children and young people.
- The CYP service held its own risk register. Review of the risk register showed there were four risks identified across the CYP service. Items on the service risk register matched the risks staff spoke about, including risks to children associated with the new ward environment bathroom area, and risks related to the running of the service, such as staffing levels and recruitment of bank staff and EPALS competency of the RMO.

Managing information

- For our main findings please refer to the surgery report.
- Staff had identified the review and management of information for children and young people as an area for improvement, following the 'You're Welcome' self-assessment.

Engagement

- For our main findings please refer to the surgery report.
- The service engaged with patients, staff, public and other health care providers to help plan and develop its services.
- Children and their families could give feedback using comments books and; 'how was your visit to hospital' survey forms.
- During inspection, the service had adopted the 'pants and tops' system, for children to give feedback about their admission to hospital. Children and young people could write or draw what was 'pants' (bad) and what was 'tops' (good) about their experience on wipe-clean pants and tops shaped cards. These were then stuck on to a magnetic washing line display board installed in the new children's ward.
- The service engaged with local stakeholders. For example, the CYP lead nurse had held two presentations for local GPs to inform them about the CYP services at the hospital.
- CYP and other staff we spoke with across the hospital were engaged with the CYP service and spoke positively about the CYP lead nurse. Staff said they could contact them at any time for support and advice.

Learning, continuous improvement and innovation

- For our main findings please refer to the surgery report.
- The CYP lead had visited the EMBRACE service and the EMBRACE team had visited Spire Hull and East Riding hospital, to ensure there was a clear pathway should transfer be required. Staff also attended sessions on transfer of the critically ill child provided by the regional paediatric critical care practitioner.

Good

Outpatients

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

The outpatient service provided consultations for Surgery, Cosmetic Surgery, Medical care and Oncology. Services were provided to children and adults of all ages (0 to 75+) and were offered to NHS and privately funded patients. The service had 15 outpatient consulting rooms across two sites with a treatment room at each location and phlebotomy on the main site. There was also an outpatient physiotherapy department with five consulting rooms and an equipped gym on the Lowfield site at Spire Hull and East Riding Hospital.

Summary of findings

We previously inspected outpatients jointly with diagnostic imaging therefore we cannot compare our new ratings directly with previous ratings. At this inspection we rated this service as good because it was safe, caring, responsive and well led. We do not rate effective for outpatients.

Since our last inspection the hospital had improved the outpatient facilities including opening a fully equipped physiotherapy department on the Lowfield's site.

Good

Outpatients

Are outpatients and diagnostic imaging services safe?

Good

We previously inspected outpatients jointly with diagnostic imaging therefore we cannot compare our new ratings directly with previous ratings.

Mandatory training

- For our main findings please refer to the surgery report.
- The hospital mandatory training programme covered all appropriate topics including; general health and safety, adult and children safeguarding, moving and handling, information governance and infection control. There were clear expectations of frequency and type of training in the training policy and what groups of staff each module applied to. Some of the training modules such as compassion in practice, managing violence and aggression and Mental Capacity Act were once only modules and would be covered as part of induction. Induction and mandatory training was given to all hospital staff including bank staff. Training provided was a combination of e-learning and face to face training.
- Data provided by the hospital showed compliance with mandatory training for outpatient, physiotherapy, pharmacy and reception staff was near or better than the expected target of 75% at September 2018 for almost all modules across all staff groups. Clinic appointment staff however were below target for all modules. However, following our inspection, the hospital provided data to show this had been acted upon and compliance for this staff group had improved. Pharmacy and nurse admin staff were also below target for the 'anti-bribery, gifts and hospitality module.'
- Staff we spoke with in outpatients and physiotherapy confirmed they were up to date with mandatory training.
- Staff in outpatients were trained in both adult and paediatric life support. Paediatric life support training was reported separately from the mandatory training above as this was role specific training. In outpatients nine of 12 staff had undergone paediatric immediate life support training and the remaining three staff members had booked training, two of 10 staff had received paediatric basic life support training and the remaining eight had booked training. In physiotherapy eight of 15 staff had completed training and the remaining seven had booked dates.

Safeguarding

- For our main findings please refer to the surgery report.
- Staff we spoke with were aware of their responsibilities to safeguard adults and children and knew whom to contact in case of any concerns.
- We saw evidence of children's and adults' safeguarding policies and procedures.
- Adult and children's safeguarding was a part of mandatory training. Staff told us they were up to date with mandatory training. Registered nurses and physiotherapists we spoke with told us their safeguarding training was at level three and that they were up to date.
- Data provided by the hospital showed; outpatients, physiotherapy, reception and admin teams had compliance levels at, or better than, the expected target of 75% for September 2018. The clinic appointment staff were significantly below target at 14% for adults safeguarding training at the time of our inspection. However, following our inspection, the hospital provided updated evidence to show they had reached100% compliance for adult and children's safeguarding training by October 2018.
- Staff confirmed they had completed safeguarding training and that they were expected to undertake an annual refresher. Managers told us that clinical staff in outpatients and physiotherapy were trained to level three in safeguarding which was above the training policy requirement.
- Whistleblowing posters were visible in staff areas and staff expressed confidence that they could speak to managers about any concerns they had about services or other staff.
- All staff felt well supported by senior staff who were readily available if they needed to escalate any safeguarding concerns.
- The hospital had a Safeguarding Responsible Manager and a Safeguarding Responsible Person, staff knew who they were and how to contact them if they needed support.
- There was easily accessible information for staff to escalate safeguarding concerns or contact local authorities when necessary.

Good

Outpatients

- Staff gave us examples of when they had discussed safeguarding concerns with the local Spire safeguarding lead, when referrals to local authorities had been made and what the outcome of their actions was.
- The paediatric clinics were managed and staffed by a Registered Sick Children's Nurse (RSCN), further detail can be found in the children's service section of the report. The outpatient manager told us it was hospital policy that young people under 18 years were only seen if there was a person with parental responsibility with them, at their first appointment, to sign a registration form on their behalf. Young people over 16 are then able to attend subsequent appointments on their own if desired.
- The physiotherapy department offered musculo-skeletal (MSK) services only, to children from around 13 years of age. There were local protocols in the department which were clear around children being accompanied by a person with parental responsibility. A child's main carer could leave a list of other approved adults who could accompany their child, such as named grandparents.
- Staff told us they considered safeguarding implications and took actions when necessary, if it was a child who had missed an appointment.

Cleanliness, infection control and hygiene

- For our main findings please refer to the surgery report.
- The departments we visited were visibly clean and we saw evidence that waiting areas, clinic rooms, and equipment were cleaned regularly. Checklists and cleaning schedules were in use for the outpatient areas we visited.
- We saw staff following "bare below the elbow" policy in clinical areas and hand hygiene policy. Soap dispensers and hand gel were readily available for staff, patients, visitors and the public to use. Dispensers were clean and well stocked.
- We observed staff using the correct hand washing technique, using personal protective equipment (PPE) appropriately.
- The department manager told us that hand hygiene audits were carried out by the infection, prevention and control lead. They gave examples of when actions had needed to be taken regarding improving bare below the elbows policy.
- The hand hygiene audit of outpatients and physiotherapy showed 100% compliance for quarter one and 100% and 92% in quarter two the area of non-compliance for physiotherapy in quarter two was staff not wetting hands before applying soap.
- Equipment in outpatients and physiotherapy was visibly clean and stickers were in place to show that cleaning had been carried out and that the equipment was ready for use. Equipment cleaning audits showed good compliance in physiotherapy and Lowfield clinic areas and although issues had been highlighted in the main outpatient area in May 2018, these had been addressed and the area was compliant in the July 2018 audit.
- Appropriate containers for segregating and disposing of clinical waste were available and in use across the departments and we saw that PPE, used linen and waste was disposed of correctly.
- There was an infection prevention and control link nurse network in operation across the hospital with an identified link practitioner for physiotherapy and the main outpatient department.

Environment and equipment

- For our main findings please refer to the surgery report.
- There was enough comfortable seating available in waiting areas with TVs magazines and health promotion literature available for patients. The Lowfield waiting area was a little cramped and it would be difficult to manoeuvre a wheel chair. However, feedback from patients was that it was a nice place to wait.
- In case of emergency staff accessed the resuscitation trolley in the adjacent radiology area.
- Curtain changes were recorded and consumable items were in date.
- Not all equipment was labelled to show when it was last serviced or maintained. However, we spoke with the manager for the engineering and services management and were told the hospital had a planned maintenance programme in place. In addition to this, compliance reports were submitted locally and nationally for environmental safety testing, for example water safety testing, fire risk assessments and air safety tests.
- There were contracts in place with specialist companies to undertake emergency repairs of equipment and maintenance. Staff told us external contractors responded quickly when equipment faults were reported.

Good

Outpatients

- The resuscitation trolley was checked every day to ensure it was in good working order. We looked at resuscitation trolley checklists and found them to be checked and signed daily. Drawer locks were in place. The trolleys were clean and tidy and all consumables were within the use by date. The oxygen cylinder was also checked and within date
- The department manager told us that if consultants wanted to use their own equipment there was an expectation that they kept maintenance and cleaning records and they signed a document for the hospital as a formal documented agreement to ensure equipment was safe to use.
- The physiotherapy department had been moved to a purpose-built unit on the Lowfield site and had all new equipment in place. The staff had been trained by the supplier/ manufacturer each piece of equipment, where appropriate. For example, training had been provided to all staff in the use of the anti-gravity machine. Staff had been assessed and signed off as competent in the use of each piece of equipment and instruction leaflets were kept with the equipment for staff to refer to.

Assessing and responding to patient risk

For our main findings please refer to the surgery report.

- There were policies, procedures and processes in place to protect patients and staff.
- Risk assessments had been undertaken in relation to patient safety, the environment and staff safety. Managers in physiotherapy and outpatients undertook paediatric environmental risk assessments and completed weekly checks. Internal audits showed these assessments were carried out and the areas were compliant with the requirements.
- There had been a recent cardiac arrest simulation within the outpatient and diagnostic area. Staff told us they had no warning this was going to take place and that the exercise went well
- Staff in outpatients told us they were all trained to basic life support level for adult and paediatric patients. For the outpatient and physiotherapy team based on the Lowfield site the emergency response was to call 999 as the resident medical officer does not cover outpatients on the Lowfield site.
- There were emergency call bells in outpatient rooms and toilets and staff told us, the hospital crash team responded to medical emergencies in outpatients on the main hospital site.
- Medical staff assessed patient referral information to see if they were suitable for consultation and or interventions at the Spire Hull and East Riding Hospital. Higher risk, complex cases were referred to the local NHS trust.
- Self-referring or GP referrals direct to the physiotherapy department were also screened for suitability and triaged to the right practitioner or therapy. The physiotherapy manager told us that they sometimes received inappropriate referrals from GPs and if this occurred they would ring the GP to discuss the referral and signpost to the most proper service. These referrals were typically for paediatric patients or stroke patients.
- We attended the daily safety huddle which was attended by all departments attend. This gave an opportunity to facilitate multidisciplinary working and a hospital wide approach to patient safety.

Nurse staffing

- For our main findings please refer to the surgery report.
- Staff and patients, we spoke with, as well as our observations confirmed that there was enough staff available to meet patient's needs.
- Within outpatients, staffing levels were based upon several factors including the number of patients expected to attend and the number, type and complexity of clinics to be held. Managers told us that activity such as diagnostic tests, x-rays and dressings was audited in relation to patient waiting times and that this information was also used to inform planning of clinic staffing. The outpatient manager told us that the minimum staffing in the department was one RN and two HCAs.
- We saw there were volunteer staff available to assist patients in the outpatient reception areas.
- At 1 July 2018 there were 13 (11 whole time equivalent (wte)) registered nurses (RNs) employed within the outpatient department.
- At 1 July 2018 there were six (4.7 whole time equivalent (wte)) healthcare assistants (HCAs) employed within the outpatient department. There was one full time and one

30-hour registered nurse vacancies at the time of our inspection. Recruitment was planned and the manager of the department told us that recruitment was not too difficult.

- The RN staff sickness rate from August 2017 to July 2018 was less than 2% for eight of the twelve months however October 2017 and March 2018 showed peaks of 67.3% and 54.1% respectively.
- The HCA staff sickness rate from August 2017 to July 2018 was less than 2% for eight of the twelve months however October 2017 and February 2018 showed peaks of 12% and 7.4% respectively.
- Staff told us that the peaks of sickness had been covered by staff working extra shifts, use of bank staff, the manager had worked more of her time clinically and staff from the ward area had also supported when needed.
- From August 2017 to July 2018, as a share of total staff bank registered nursing staff used in the outpatient department ranged between 7.8% and 21.5% from August 2017 to July 2018. The number of shifts covered by bank RNs from May to July 2018 averaged 26 shifts a month.
- From August 2017 to July 2018, as a share of total staff, bank healthcare assistants used in the outpatient department ranged between 0% and 6.9%. The number of shifts covered by bank HCAs from May to July 2018 averaged three shifts a month.
- The hospital had its own bank of staff to call on when needed, to cover short notice absence. Outpatients had recently recruited two members of bank staff. There was no reported use of agency staff in outpatient areas in the last 12 months. There were no unfilled shifts from May to July 2018.
- Staff turnover in the department from August 2017 to July 2018 was 5.9% for outpatient RNs and 11.1% for HCAs.
- The physiotherapy manager told us that the minimum staffing in the department was one registered physiotherapist, one physiotherapist assistant and a receptionist.

Medical staffing

- For our main findings please refer to the surgery report.
- Medical staff in outpatients had practising privileges with the hospital and held clinics for both NHS and self-funding patients. All clinics were consultant led.
- There were 238 doctors (more than six months in post) with practising privileges at the hospital, all had their registration confirmed in the period from August 2017 to July 2018. From August 2017 to July 2018, 101 doctors with practising privileges had carried out no episodes of care, 36 had carried out one to nine episodes of care, 73 had carried out 10 to 99 episodes of care and 39 had carried out more than 100. During this time one doctor had their practising privileges removed and had been referred to the General Medical Council.

Records

- For our main findings please refer to the surgery report.
- Records used in the outpatient department were a mixture of paper based and electronic information that included test results, reports and images. Medical notes and referral letters were not held electronically.
- All patients attending the hospital had a full set of medical records stored on site for a maximum of a four-month period. After this, they were transferred to an off-site storage facility.
- All clinic notes were arranged 24 to 48 hours in advance, which meant patients should never attend clinic without medical records being available.
- Staff reported that records were usually available in a timely manner for clinic appointments and the department estimated that records were unavailable less than 1% of the time. For the three months before the inspection 0.15% of patients were seen without a full medical record being available.
- In the event of records being unavailable for a patient's appointment, a temporary set of records was created, with the referring GP letters attached which included relevant medical history. Managers told us that in all cases, the patient would be risk assessed to determine whether temporary records or rearranging the appointment would be the most appropriate action. Staff told us that it was extremely rare for a patient to attend without records being available.
- Managers told us that any patient records which are off site are requested prior to the appointment and are available on next day delivery. There was a process in place to ensure medical records were transported securely around the hospital, between sites and stored securely when not in use.
- The hospital policy was that consultants did not take medical records out of the hospital. However, the

hospital required that all consultants were registered with the Information Commissioner's office and were personally accountable for the protection of information.
- Records were stored securely away from waiting patients.
- We looked at four sets of notes in the physiotherapy department and four sets in the main outpatient area and found them to be complete with both NHS and Spire records attached, all had referral letter present and all had consultant letters following initial consultation. Records and letters were all signed. Physiotherapy records contained the patient's treatment protocol and outcome measures were recorded.
- Managers told us that records audits were part of the routine audit programme. We saw that the physiotherapy team had reported an audit in January 2018 that showed 94% compliance. An action plan had been implemented to communicate the results to staff and improve standards. We were told that any issues with records were highlighted with all staff to raise awareness of where standards had slipped and if there were recurrent issues noted with an individual practitioner this was raised on a one to one basis.

Medicines

- For our main findings please refer to the surgery report.
- We were told that drug stocks were checked regularly and a more formal stock take was completed twice a year. We checked drug cupboards and found that all drugs were in date.
- Prescription pads were locked in the drug cupboard and nursing staff gave these to Consultants on an individual patient basis. Records were kept of who had used each prescription.
- The onsite pharmacy dispensed the prescribed medicines for outpatients. Prescription charges were covered as part of the packages of care commissioned for NHS outpatients.
- Prescription charges for private outpatients were added to, or included in, consultation fees depending on the treatment plan bought. Improvements had been made to ensure charges were made clear to patients before they attended for their first outpatient appointment.
- We checked records of drug fridge temperatures and found these were checked daily. Records were up to date with no gaps and that fridges had been kept within the recommended temperature range.
- Flu vaccines were available to patients and staff and were administered in the outpatient department, under a patient group directive (PGD). The nurses administering flu vaccines had received training from the occupational health nurse.

Incidents

- For our main findings please refer to the surgery report.
- There was a process in place to enable reporting of all incidents and near misses. Managers told us incidents were subject to a risk-appropriate level of investigation with serious incidents requiring investigation (SIRI) using a root cause analysis method.
- There were mechanisms in place to ensure learning from incidents and improvements made where necessary. Staff told us that they received information (which included lessons and actions) about serious incidents from local services and from other hospitals in the Spire group.
- Staff told us they received safety alerts and updates from daily huddles via email.
- Managers and staff were familiar with duty of candour requirements and the need to be open with patients when things went wrong.
- From August 2017 to July 2017 there were no never events or serious incidents relating to this service.
- The service had reported 104 clinical incidents and 22 non-clinical from July 2017 to June 2018. The largest number of incidents reported was in relation to missing information / mis-labelled specimens, surgical site infections detected at follow up appointments and cancellations the majority of which were patients who did not attend for appointments.
- The outpatient manager told us about an emergency transfer from the hospital that had been investigated as a serious incident, they were aware of the outcome of the investigation and that the hospital were to undertake some improvement actions.
- The manager told us they could filter incidents to their own department and generate their own reports.
- There had been no incidents in the last 12 months that had triggered a formal duty of candour response.

Safety Thermometer (or equivalent)

- For our main findings please refer to the surgery report.
- Safety information such as Surgical site infections and incidents was on display in the outpatient areas.

Are outpatients and diagnostic imaging services effective?

We do not rate the effectiveness of outpatient services.

Evidence-based care and treatment

- For our main findings please refer to the surgery report.
- Most of the operational policies were developed by Spire group nationally. Those we reviewed included reference to and followed nationally recognised best practice guidance.
- Policies and protocols were available on the hospital IT system in the 'book of knowledge' we saw that some protocols and a small number of policies had been printed for staff to access more easily in the physiotherapy department. The protocols we looked at in the physiotherapy department were all in date, were clearly referenced with the evidence base and had a review date.
- Findings of audits and inspections were discussed at team meetings so all staff were aware when any changes to practice were needed.

Nutrition and hydration

- For our main findings please refer to the surgery report.
- Patients had access to tea and coffee and water while waiting in the outpatient areas.
- Patients told us staff offered them refreshments when they arrived and offered to bring them to patients who needed help.

Pain relief

- For our main findings please refer to the surgery report.
- Pain relieving medicines and local anaesthetics were used for minor procedures in the department.
- The physiotherapy team used visual analogue scores (VAS) to measure a patient's experience of pain at the start and end of treatment as well as throughout the therapy.
- The physiotherapy manager was chair of the hospital pain committee and told us about a new simpler pain tool the hospital was going to trial with orthopaedic patients. The tool would use a score of one to four instead of the traditional one to 10 and would have clear descriptors and pictograms to help patients use the tool.
- The outpatient department manager told us about a wooden pain board they had to be used with patients suffering from dementia.

Patient outcomes

- For our main findings please refer to the surgery report.
- The hospital had made some improvements to how they used audit data in outpatient services.
- Spire outpatient and physiotherapy departments had a comprehensive audit programme that included; clinic utilisation and waiting times audits, a range of IPC, environment and equipment audits, a physiotherapy length of stay audit, documentation, patient satisfaction and a cosmetic cooling off period audit.
- There was a recommended two-week cooling off period for cosmetic surgery patients, however, we were told that if patients wish to go ahead to surgery within two weeks they could sign a disclaimer. The audit covering the period from January 2018 to March 2018 showed full compliance with the cooling off period requirement. Most cosmetic surgery patients were referred to Spire by their GP. The cosmetic policy had recently been revised and included the need for psychological assessment and liaison with GPs if felt necessary for self-referring patients.
- The physiotherapy department was collecting data from audits and patient outcomes to look for trends or cause and effect and to lead to improvements. They were continuing to consider additional data they could collect or use in a different way. The physiotherapy team audited length of stay for joint replacement patients which they told us was currently a maximum of five nights. It was felt that the reduced length of stay was an outcome of the effectiveness of the whole pathway including pre-operative therapy groups in the outpatient physiotherapy department. The manager told us the hospital benchmarked as having a shorter length of stay than other Spire hospitals, the five-night target was achieved with 94% of patients.
- In addition to pain scores, the physiotherapists used the Patient-Specific Functional Scale(PSFS) to collate information for one insurance company. This is a self-reported, patient-specific measure, designed to assess functional change. This information was collated

and reported back to the insurer, to determine the effectiveness of treatment. The physiotherapy team were planning to roll out the use of this measure for all patients to determine their effectiveness and help identify any areas that needed to be improved. The physiotherapy manager told us that this also helped therapists assess whether patients were ready for discharge.

- Consultants working in outpatients were involved with research and monitoring effectiveness of the treatments they offered.
- We saw evidence that audits were undertaken, and action plans documented, regarding waiting times and appointments. An audit of one clinic in May 2018 showed that the consultant arrived 16 minutes late and the waiting time averaged 19 minutes. The outpatient manager told us they had audited this clinic due to there being issues with waiting times. They had not yet fed back the results to the consultant concerned or discussed with them how improvements could be made, however, there was a deadline for action of September 2018.
- We were also made aware that consultants sometimes double-booked appointment slots and this had caused issues in clinics. The outpatient manager told us administration staff had been asked not to do this anymore but it was unclear if or how this directive had been communicated to the consultants involved. The action plan did not mention communicating with the consultants or detail if there were any further actions needed from the administration team.
- Waiting times for x-rays had also been audited from outpatients as this had an impact on the overall waiting times for patients in the department. The manager told us that they had discussed the findings with the x-ray manager and improvement actions had been taken. It was unclear from the action plan what actions were recommended or had been taken.
- The latest physiotherapy waiting time audit had shown that all patients had been called in at their appointment time.
- Patient outcomes relevant to outpatients were also monitored through complaints and cancellations, which were included on a clinical scorecard with quality measurements for other areas. This was submitted to the local commissioners on a quarterly basis and was used to benchmark against other Spire hospitals. For example, the hospital audited the percentage of eligible females who had a pregnancy test documented in their medical records prior to treatment or surgery with results reported following a local audit of 20 sets of patient notes per quarter. The Spire Hull result for the last two audits was 100% which was better than the Spire average of 99%
- We saw that outpatient departments took part in BUPA audits of the environment in outpatient areas and that the areas were fully compliant.

Competent staff

- For our main findings please refer to the surgery report.
- Staff we spoke with told us that induction was thorough and structured. New starters, which included bank staff, were given a "buddy" and given a three-month induction / probationary period.
- The outpatient manager told us that staff competence was maintained through additional training and assessment of core competencies which were signed off. Core competencies had been revised during the last 12 months and all staff in outpatients had been signed off as being competent.
- The outpatient manager told us that if it was difficult to maintain staff competence regarding a specific task or role then the role was reviewed. For example, staff had been unable to access updates regarding application of orthopaedic casts, this was reviewed, and the practice ceased when the training needed could not be sourced. The role of cast application reverted to consultants.
- Staff were attending a sepsis awareness update during our inspection. HCAs had received further training in phlebotomy, suture removal and wound care. Staff moving and handling competence was assessed by members of the physiotherapy team.
- The hospital had a process in place to assure itself that consultants, providing outpatient services, held current indemnity, GMC registration, had an annual appraisal and to confirm revalidation where necessary.
- The hospital's appraisal year ran from January 2018 to December 2018 and the target for completion was 75% by September 2018. More than 90% of outpatient staff had received an annual appraisal by July 2018.
- Staff told us that they had been supported with training relevant to their role and career development within the hospital. Support with learning had been supported by immediate line managers and the hospital director as well as more specialist support and support networks available through the wider Spire group. Staff could

access training regarding to lead or link roles or management and leadership. Staff had recently received update training about customer care which had been identified as a learning need through the analysis of themes from complaints.
- Managers and staff, we spoke with told us that outpatient staff received chaperone training and had been assessed as competent to undertake this role. A chaperone audit had been added to the audit programme for later in the year.
- Physiotherapists took part in peer reviews to reflect on their practice and maintain and improve competence.

Multidisciplinary working

- For our main findings please refer to the surgery report.
- We saw there was good teamwork and positive relationships between staff of different disciplines and found evidence of multidisciplinary (MDT) working within patient records.
- There were good examples of internal and external multidisciplinary team working. For example, physiotherapists worked closely with consultants and GPs as well as with other AHPs and nursing staff to ensure patients were provided with individualised treatment plans.
- We saw that physiotherapist consulted with medical staff on the development and review of pathways and therapy protocols.
- The outpatient manager gave examples of liaising with the radiology manager about availability of x-ray slots to facilitate one stop clinics and to stream line/ reduce waits for patients in clinic who needed x-rays.

Seven-day services

- For our main findings please refer to the surgery report.
- Outpatient clinics were accessible at varying times of day and evening from 8am until 9pm and Saturday mornings.
- Physiotherapy services were available 8am to 5.30pm for outpatients Monday to Friday and Saturday mornings. The department offered later appointments until 8pm on a Tuesday and Thursday evening and flexible appointments for outpatients outside of these times and at weekends if asked.

Health promotion

- For our main findings please refer to the surgery report.
- We saw lots of health promotion information in the outpatient departments. For example, the information included; healthy eating, stopping smoking, breast awareness, various mental health literature and hand hygiene for patients. There was also lots of other information for patients including information about costs and finance, cosmetic surgery, allergy notices, adult and children's safeguarding, information about physiotherapy and a guide to treatments and services available at the hospital.
- Outpatient staff had received training in offering brief information and advice to patients about alcohol use and smoking.

Consent and Mental Capacity Act

- For our main findings please refer to the surgery report.
- Staff showed knowledge and understanding of safeguarding vulnerable adults. They had received adult safeguarding training that had included Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS).
- Staff demonstrated a good understanding of informed consent and there were clear policies in place.
- We saw that verbal or implied consent was obtained from patients before care and treatment interventions, such as obtaining specimens, routine diagnostic tests and the checking of height, weight and other physiological signs.

Are outpatients and diagnostic imaging services caring?

Good

We previously inspected outpatients jointly with diagnostic imaging therefore we cannot compare our new ratings directly with previous ratings.

Compassionate care

- For our main findings please refer to the surgery report.
- Patients told it was a really good experience using services at the hospital and that all staff were always polite and helpful. Physiotherapy staff were described as very professional and knowledgeable. Staff who

answered calls about appointments and receptionists were also described as being very helpful. Staff everywhere were described as kind and caring, they were 'lovely' 'couldn't fault them'.

- Both outpatients and physiotherapy outpatients carried out patient surveys which gave very positive feedback. Patient surveys included a waiting times survey. Friends and family test feedback from February 2018 to July 2018 was extremely positive with 95% to 100% of patients saying they would recommend the service. However, the response rate ranged from 10.4% to 24.3% in the same period.
- During our inspection we saw patients being treated respectfully by all staff. Staff were wearing name badges and were seen to introduce themselves to patients, politely and professionally.
- Reception staff were welcoming to patients as they entered the hospital and gave clear instructions and advice in a helpful, caring and compassionate manner.
- We saw patient's privacy was respected and the environment in the outpatient clinic area allowed for confidential conversations. However, the reception area was very open and lacked privacy for patients booking in.
- Notices offering chaperoning were displayed and staff told us this was provided whenever requested.
- Because of patient feedback, improvements had been made to appointment letters and the inclusion of additional information to ensure insurance and self-funding patients were fully informed of processes and charges.

Emotional support

- For our main findings please refer to the surgery report.
- A member of the nursing team was made available to accompany a consultant when breaking bad news to patients and was then also available to provide support and answer questions from the patient and relatives until the patient left the hospital.
- A specialist nurse offered support to patients undergoing cosmetic surgery.
- Patients two spoke with told us they had been offered chaperones but had not needed one.
- We found that a call recording facility had been introduced so staff could listen back on difficult calls for debriefing and learning purposes regarding supporting and communicating effectively with distressed patients. Staff told us they could de-brief at team meetings.

Understanding and involvement of patients and those close to them

- For our main findings please refer to the surgery report.
- We saw staff spending time explaining procedures to patients using both verbal and written information. Patients told us they were given time to ask questions and these were answered in a way they could understand.
- Patients and their representatives told us they were involved in decision making about their care and treatment and that they were clear about treatment options.
- Most of the patients we spoke with were satisfied with the information they received about their appointment, what to expect and requirements about tests and procedures.
- A patient using health insurance told us that information about appointments, tests and costs was included in the outpatient appointment information
- All six of the patients we spoke with told us they had been given enough information before and during their appointments and they had been given the opportunity to ask any questions they had.

Are outpatients and diagnostic imaging services responsive?

Good

We previously inspected outpatients jointly with diagnostic imaging therefore we cannot compare our new ratings directly with previous ratings.

Service delivery to meet the needs of local people

- For our main findings please refer to the surgery report.
- Service planning was responsive to the needs of local people and supported delivery of services offered by local NHS trusts. The service received referrals from three local trusts under service level agreements and had an emergency transfer agreement in place with one of them.
- The outpatient service provided consultations for Surgery (orthopaedics, ENT and general surgery accounted for the majority of outpatient activity) were the, Cosmetic Surgery, Medical care and Oncology. Services were provided to children and adults of all ages

(0 to 75+) and were offered to NHS and privately funded patients. The service had 15 outpatient consulting rooms across two sites (Spire Hull and East Riding Hospital and Lowfield Clinic) with a treatment room at each location and phlebotomy at the hospital. There was also an outpatient physiotherapy department with five consulting rooms and an equipped gym on the Lowfield site.

- Surgical outpatients included; breast care, ear, nose and throat, cosmetic surgery, orthopaedic surgery, general surgery (including weight loss surgery) ophthalmology, audiology. Medical outpatient consultations were available for a wide range of conditions such as; heart conditions, dermatology, pain and migraine. A health and wellbeing service for men and women was also available.
- The physiotherapy department offered a wide range of services, including assessment and treatment of patients attending the hospital for surgery, a variety of therapies including pain management, Pilates (for back pain sufferers) and a sports injury service. The department was able to offer state of the art anti-gravity equipment for rehabilitation of patients who had suffered joint injuries or undergone joint replacement. The department also had a contract with a local council to provide an occupational health service. Self-funding patients could refer themselves for physiotherapy assessment and treatment. The department did not specialise in paediatric physiotherapy but could offer MSK services to older children from around the age of 13 years. The physiotherapy department was open from 8am to 6pm for outpatients. The department offered flexible appointments for outpatients outside of these times and at weekends if requested.
- Since our last inspection services had been developed on the Lowfield site, this had enabled development and refurbishment of the physiotherapy department (located on the main site), additional clinic rooms, a focus of some services on one site and additional parking for the hospital as a whole. An outreach clinic for ear nose and throat patients was also provided at Diadem.

Meeting people's individual needs

- For our main findings please refer to the surgery report.
- The hospital offered access to translation services for patients where English was not their first language. The hospital had a local process to follow to access services as required through a national contract across the Spire Group. The process made it clear that family members could not be used as interpreters in line with best practice in any clinical matter.
- Spire Healthcare Limited consent policy gives advice for staff on when an interpreter is required and clearly notes that; 'it is not appropriate to use children under the age of 16 years and preferably not under 18 years to interpret for family members who do not speak English.' It was not clear whether this was for clinical matters and the provider advised this policy would be updated to make this clear.
- The hospital accommodated patients with a learning disability and mild dementia. The need for reasonable adjustments was determined at first outpatient appointment. There was a hospital lead for safeguarding and dementia to give support to patients and staff when needed. Staff in outpatients had sourced a dementia friendly clock and a wooden pain board. Staff did not always know if someone with dementia or a person with a learning disability was going to attend the department. Sometimes this information was available from referral letters but not always. Staff tried to accommodate people's individual needs by making reasonable adjustments and involving family members or a carer where possible. When staff knew people may have additional needs they would arrange appointments around those needs.
- Written information leaflets including the complaints leaflet could be made available in several different languages if required.
- For cosmetic surgery, free mini consultations were offered and all patients were given a cooling off period.
- One-stop clinics were in place to reduce the need for patients to attend on numerous occasions – for example breast services and pre-consultation imaging. There was a specialist nurse available to support patients undergoing breast surgery.
- When patients needed follow up appointments or investigations they were informed during their consultation and later received a copy of the consultation letter to the GP. Follow-up appointments were made at reception before leaving the hospital.
- At our inspection in 2015, patients told us that local parking was difficult and caused some anxiety about attending appointments and potentially receiving a parking ticket. The hospital now included a map and information about car parking to patients with the

appointment confirmation letter. The development of the new Lowfield Clinic has provided an additional 200 parking spaces. This has provided off-site parking for staff and additional capacity at both sites for patients and visitors. None of the patients we spoke with had any difficulties with parking or accessing the clinic.

- Outpatient appointment letters sent to patients also included a patient registration form, a fees form which included information on charges and paying for treatment. The fees information had been added as a paper copy attached to the letter as result of patient feedback that had indicated a lack of information about additional charges, such as prescription charges.
- Managers told us that flexibility of appointment times was offered and most consultants could offer evening or weekend slots.
- The physiotherapy team also offered telephone advice or support to patients they had seen in the department. For patients beginning Pilates all patients were given a one to one assessment and instruction before joining a group to ensure they understood the exercises and instructions to participate fully in the group and to avoid any discomfort or embarrassment if instructions in the class were not understood.

Access and Flow

- For our main findings please refer to the surgery report.
- The hospital accepted self-funded and NHS referrals for children and adults from a large catchment area. Patients were mainly referred to the Spire consultants by the patients' GPs. Patients could self-refer for cosmetic treatments and there was a system in place to contact the patient's GP to determine whether there were any contraindications for the treatment requested, prior to treatment commencement. Physiotherapy received referrals from GPs, saw pre- and post-operative patients and self-referring patients.
- Electronic referral systems were in place for both NHS and self-funded referrals with a fax system for GPs who did not yet use the electronic systems.
- NHS Surgical referrals were screened and triaged by the outpatient manager as to suitability for treatment at the Spire Hull and East Riding Hospital. There were a number of exclusion criteria used to assess the suitability of patients. Other referrals went direct to the consultants who made the decision regarding whether it was appropriate to see and treat a patient at the Spire Hull and East Riding Hospital.
- Most of the patients attending the outpatients' and physiotherapy department were NHS funded. From August 2017 to July 2018, 85% of patients seen were NHS funded and 15% were private patients. During this period, 8,736 NHS and 2,046 private patients attended the hospital for first appointments. There were 23,496 NHS and 3,862 private follow-ups. New to follow up ratios were 1 to 2.7 for NHS funded patients and 1 to 1.9 for privately funded patients.
- From August 2017 to July 2018, there were 38,140 outpatient and physiotherapy attendances, 830 (around 2%) of these were children; four appointments were for children aged 0 to two years, 607 were for three to 15 years and 219 were for 16 to 17 years.
- Administration managers told us the service aimed for patients to be seen within two weeks of referral and there were systems in place to help the service meet this target. The admin team could liaise with consultants to offer extra appointments, or with GPs to arrange for a patient to be seen by a different consultant if that was acceptable.
- Appointment slots were ring fenced through the choose and book system for NHS patients and these appointments were opened up to self-funded patients if they were unused and there was a separate booking system for self-funded / insured patients.
- If appointments were made at short notice the admin team would ring patients with the appointment details. Staff told us they would rearrange appointments for patients if they were unable to attend. Managers told us they monitored the achievement of the two-week wait target, however we did not see any data relating to the achievement of this target.
- Four of the six patients we spoke with told us they had waited over two weeks for their appointment. Three patients told us they had not been given a choice of appointments. However, another patient who attended regularly told us they had been offered a few appointments but on this occasion, had waited longer than usual for their appointment which was now eight weeks late. Another patient told us their appointment had been cancelled and re-arranged for four weeks later.
- Staff told us it was very rare to cancel a clinic and it would usually be due to a consultant being ill. When clinics were cancelled, admin staff told us they rang patients to reschedule to ensure they were aware of the cancellation, especially if this was within five working

days. One patient told us their follow up appointment had been cancelled by the hospital and their replacement was eight weeks later, however when the patient rang the hospital the appointment was brought forward. The patient told us they had previously had a few appointments cancelled and rearranged.

- Monitoring of cancelled clinics, reasons why and timing of rescheduled appointments had been introduced and we saw that collated information was presented at the heads of department meeting. Monitoring of clinic start times and the length of time patients waited in department had also been introduced and was undertaken as a quarterly audit. From January 2018 to March 2018 there were 544 patients affected by clinic cancellations which was an improvement on the earlier three months when 746 patients were affected.
- Monitoring of clinic times had led to improved start and wait times by changing the start time of one clinic which had repeatedly started late and subsequently led to delays for patients. There were notices in the reception area to inform patients that if they had been waiting 15 minutes or more for their appointment, they should speak to reception and enquire about the delay. Staff told us if they knew a clinic had started late or was going to run late they would inform the reception staff so patients could be kept informed.
- We spoke to four patients in the main outpatient area, three had not waited past their appointment time but one patient had waited 30 minutes and had not been told why their appointment was late. Another patient in the physiotherapy area told us they waited 25 minutes and had not been seen yet, however a member of staff had given them a self-assessment questionnaire to fill in and was giving them time to complete this.
- Outpatient staff had a system in place to contact, by telephone, patients who did not attend (DNA) their appointment and offered an alternative appointment. Managers told us they were considering how best to collect and collate DNA data and how this could be best used. Physiotherapists rang patients who DNA post-operative appointments and had found that the appointment cards had not seen as they had slipped inside other discharge information. The physiotherapists now handed appointment cards to patients and had seen their DNA numbers reduce because of this. The outpatient department DNA rate from April 2018 to June 2018 was 4.7%, the administration team had altered their practice in relation to patients who DNA to collect information to better understand the reasons for this with the aim of reducing the rate.
- Managers told us they had made some changes in the appointments office as they had noticed long call waits for patients, and phones not being answered. There was now a dedicated, manned desk for telephone calls only. Managers told us the change had resulted in tangible improvements in call answering however, the telephony system did not have an automated reporting system to obtain data from.
- The physiotherapy manager told us they tried to ring patients with an appointment within 24 hours of a referral.

Learning from complaints and concerns

- For our main findings please refer to the surgery report.
- Complaints could be raised through the hospital's website, through patient feedback forms, patient forums, social media, verbally to any member of staff as well as in writing and by email. 'Please talk to us leaflets' explaining the complaints process were available in the outpatients' departments waiting areas. Multi-language complaints information posters were displayed in the reception areas. Physiotherapy comment cards were available in reception for patients to leave feedback for that service.
- Complaints about outpatients were investigated by the Matron who involved and collated information from the other members of the team involved in the patient's treatment.
- We found that, complaints were discussed at safety huddles and team meetings to ensure widespread staff awareness of issues that gave rise to a complaint and so that learning could be shared. Complaints were also shared with all staff through the governance newsletter.
- There were 12 complaints relevant to the outpatient area from January 2018 to August 2018 with issues highlighted around appointment or consultant availability, waiting times, onward referral, communications with GPs following consultations and staff attitude. We saw that complaints were taken seriously, and the hospital had taken actions to improve patients' experience. For example; the hospital was exploring the possibility of direct onward referral if they received an inappropriate referral from a GP to save time for the patient going backwards and forwards; the

hospital were also reviewing clinic waiting times and reasons for long waits or late starts and they had reviewed secretary cover to ensure timeliness and quality of clinic letters was maintained when consultants' named secretary was on leave.

Are outpatients and diagnostic imaging services well-led?

Good

We previously inspected outpatients jointly with diagnostic imaging therefore we cannot compare our new ratings directly with previous ratings.

Leadership

- For our main findings please refer to the surgery report.
- The service was led by a head of department for the main outpatients' department and a head of department for the physiotherapy department. The outpatient manager was responsible for outpatients on the main hospital site, the clinics and staff at Lowfield and the outreach clinic at Diadem, a department sister supported the manager and led the service provided on the Lowfield site on a day-to-day basis. The physiotherapy lead managed the delivery of outpatient and inpatient physiotherapy. Both managers spent part of their time working clinically.
- The hospital had a clear management structure in place with clear lines of responsibility and accountability. The outpatient and physiotherapy managers reported to the clinical lead and then the hospital matron.
- The hospital matron was new in post and the former matron had taken up the role of clinical lead, staff were aware of these changes. The department managers and other staff told us that the matron and clinical lead were visible and approachable.
- Staff in all areas said they were well supported by their managers and senior managers who were visible and accessible. Staff felt that managers communicated well with them and kept them informed about the running of the departments. Some staff told us they had not been very involved in the recent service changes but had been made aware of what was going on and the need for the recent redundancies. Staff indicated that they were satisfied with the information given and level of involvement.
- Staff we spoke with felt they were listened to and engaged in the organisation. They felt managers were interested in their work and encouraged them to express ideas for service development.
- A large proportion of staff had worked for Spire for many years and had benefitted from training and development to improve their performance. One manager we spoke with told us how they had been developed and trained over the years to be able to progress and take on a leadership role.
- We attended the daily safety huddle for all heads of departments led by the hospital director. The huddle was well structured and involved department leads from all areas. The huddle gave heads of department the opportunity to identify any pressures within their departments, escalate or de-escalate risk and share important information for the day that was relevant to other departments. Heads of department were seen to be fully engaged with the meeting and that this was a valuable communication strategy to promote patient safety and experience as well as a way of engaging staff in the running of the hospital as a whole.
- Managers told us that they aimed to have staff meetings every, one to two months but this was often difficult. We saw there had been two outpatient team meetings since January 2018 and three physiotherapy outpatient team meetings since April 2018. Minutes of meetings showed a comprehensive agenda which included updates about incidents, complaints, audits and actions, changes to practice, areas for improvement and successes/ progress. They also included information about service developments and improvements or upgrades. This ensured staff knew what was happening across the hospital as a whole and that learning from complaints and incidents from the wider hospital was shared with all teams.

Vision and strategy

- For our main findings please refer to the surgery report.
- Staff we spoke with displayed engagement with the corporate Spire vision and five overarching strategic aims which were; to be famous for quality and clinical care; to be the first choice for private patients; to be the most recommended customer experience; to be the best place to practice and to be the best place to work.

Good

Outpatients

- We found that the outpatient and administration teams had been involved in developing their own vision or aims for each of their areas and that these reflected corporate and hospital objectives.
- For example; the outpatient department aimed; to offer a seamless patient journey; to minimise waiting times; to provide high quality care to patients ensuring that staff are competent within their scope of practice and to support consultants to deliver an excellent service
- Physiotherapy aimed; to deliver current, consistent, professional and friendly patient care; to communicate clearly to patients, families and staff; to encourage feedback to help drive innovation and improvements in the service; to be committed to delivering expert inpatient and outpatient physiotherapy care based on evidence based practice and ongoing specialist learning; to demonstrate effective team working and communication with our consultants and the MDT which puts patients at the centre of their physiotherapy care
- Appointments and reception staff also wanted to provide an excellent, efficient, caring service that would provide the best experience for patients, clients, consultants and GPs using the hospital services.
- Staff were clearly proud to work at the hospital, the service they delivered and wanted to provide patients with the best experience possible.
- Organisational expected behaviours and values were integral to staff performance, development and appraisal 'energising excellence'.

Culture

- For our main findings please refer to the surgery report.
- Staff and managers told us the outpatient departments had an open culture. Staff of all grades spoke positively about the culture within the hospital and they were clearly passionate about delivering a high-quality service and providing patients with the best experience possible. Staff who had joined the hospital more recently told us they were made to feel welcome by the whole team and had been supported.
- Staff told us they would be confident to raise a concern with their managers and that this would be investigated appropriately. They told us they would have no hesitation in raising concerns, if they had any, and that in the first instance they would go to their immediate line manager. We saw posters displayed in outpatient and physiotherapy areas informing staff of the freedom to speak up guardian.
- Staff told us the hospital management team were welcoming of staff ideas for improvement, supportive of staff development and encouraged staff to report and learn from incidents. Staff felt they were encouraged to seek feedback from patients and take immediate action when issues or concerns arose.
- A positive culture was evident within the outpatients' low turnover and length of staff service.
- The appraisal system "Enabling Excellence" was underpinned by Spire's behaviours and helped ensure that patient experience and customer service were top priorities for all staff.

Governance

- For our main findings please refer to the surgery report.
- There was an established governance committee structure to support sharing of information and drive improvement.
- Staff we spoke with were aware of governance arrangements and feedback from governance and management meetings was given at team meetings. All staff had access to the minutes of meetings on the hospital intranet.
- We found that heads of outpatient departments attended the hospital leadership team meetings where incidents, complaints, performance against audits and potential items for the risk register were reported and discussed.
- Incidents, complaints and new policies were reported to and discussed at the clinical governance committee and at the medical advisory committee.
- Staff were given feedback about incidents and lessons learned, comments, compliments and complaints at team meetings where audits and quality improvement were also discussed.
- Registration status had been verified for 100% of staff in outpatients.

Managing risks, issues and performance

- For our main findings please refer to the surgery report.
- Recording of risks and mitigations and regular review of risks had improved since our last inspection. The outpatient manager told us that the risk champion had met with heads of departments and was to attend team

meetings to explain the risk registers and how these should be reviewed and updated. There was an expectation that actions to mitigate risks were clear and entered on the electronic system. The risk lead was responsible for monitoring compliance with this approach and sending reminder alerts to the heads of departments when necessary.

- The hospital had a risk register in place for business and clinical risks and managers escalated new risks when necessary. The outpatient manager did not have a separate risk register for their department but felt that the hospital register covered the department's risks.
- Staff knew how to escalate risks within their department and there was opportunity at the daily safety huddle for heads of department or a representative to raise immediate risks to the wider management team and the hospital director. Heads of department could also raise any new risks through the governance meeting structure as appropriate. We saw an example, in team meeting minutes, where a concern had been raised about the safety of reception staff on the Lowfield staff. The hospital management team had responded appropriately, and an intercom had been installed so doors could be locked by staff at quiet times and opened to let people in when they had identified themselves.
- The outpatient manager told us a rapid response meeting with the heads of department, chaired by the governance lead was held weekly, to discuss recent incidents and ongoing investigations, any immediate actions that needed to be taken and to ensure the whole hospital was aware of implications for all departments
- Performance was monitored and managed through a programme of audits which all had an expected level of compliance. We saw that audits were reported and shared on a clinical performance scorecard. Not all of the benchmarked audits were relevant to the outpatient areas but there were other audits in these areas.
- We found that the audits of waiting times and appointment bookings had found some issues and some actions with deadlines had been documented. However, these tended to be single actions which lacked detail and did not include any subsequent actions needed by staff in other departments such as x-ray or appointments, to make the improvements aimed for.

Managing information

- For our main findings please refer to the surgery report.
- All staff had access to the hospital intranet to gain information relating to policies, procedures, NICE guidance and e-learning.
- Minutes from meetings and important documents such as the hospital risk register could be accessed by staff on the intranet.
- Staff could access patient information such as x-rays, medical records and physiotherapy records appropriately through electronic and paper records.
- The typing of outpatient letters was outsourced to an independent company.
- Compliance with information governance training for staff in outpatients, physiotherapy and associated admin and reception teams was at or better than the September 2018 target of 75%.
- We found that patient records were stored safely and securely away from patients and that there was a secure transport system in place for transferring records from one site to another.

Engagement

- For our main findings please refer to the surgery report.
- Staff were seen to be passionate about their roles and invested in the success of the hospital. Staff we spoke with were engaged in the future of their services and the desire to be excellent providers of care. Some of the staff we spoke with were proud to have received recognition from their colleagues and managers for long service and or good work and achievement.
- All staff we spoke with felt valued by the hospital, their line managers and the senior management team. Staff gave examples of engagement activities and rewards the hospital offered these included; an annual staff party, a free birthday lunch, long service awards and inspiring people awards.
- Staff said the hospital director was 'always around the hospital and knows every body's name', that managers had an open-door policy and were very approachable.
- Other staff told us that work life balance was respected and that the investment in their training made them feel valued.
- We saw that where a staff member had a led on a piece of work such as reviewing, updating or writing a policy or treatment protocol they were clearly recognised for that work by being a named author on the document.

Good

Outpatients

- The hospital director held a daily safety huddle for managers from all areas, which included special thanks from patients to staff and recognition of individuals' good work from other staff. Managers cascaded the key messages from the huddle to their own teams.
- Patient engagement occurred in several ways, for example, patient feedback was encouraged, and surveys were undertaken regarding patient experience and waiting times. Compliments were also collected and shared with staff and or used in appraisal and revalidation. All feedback was shared to promote improvement from a patient perspective and improvements were displayed on 'You said we did' boards in the outpatient waiting areas. Patient experience surveys showed a high level of satisfaction.
- Managers told us that patient feedback had been used to inform developments such as the new physiotherapy gym, increasing outpatient clinic capacity, developing evening services and improving car parking. We saw that staff valued patient feedback and the hospital employed volunteers who had previously been patients.
- The hospital was to take part in the pilot of a new outpatient specific feedback survey later in the year, which will be completed online.

Learning, continuous improvement and innovation

- For our main findings please refer to the surgery report.
- Staff told us they were encouraged to propose innovative ideas for service developments and or to improve patient experience. Outpatient department staff told us they had suggested the nursing station be moved from partway down the corridor which was invisible to patients waiting, to a room opposite the reception and waiting area. This was so they would be more visible to patients and so they could see if patients were waiting longer than expected. They hoped this would enable staff to be able to respond more quickly to any patients that had any difficulties they could help with. Staff told us this his suggestion had been taken on board by hospital managers and the change was to be implemented as part of the department refurbishment.

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

The hospital provided diagnostic imaging services including x-ray, ultrasound, Computerised Tomography (CT), Magnetic Reasoning Imaging (MRI), Fluoroscopy, Angiography and Mammography.

Summary of findings

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. At this inspection we rated this service as good because it was safe, caring, responsive and well led. We do not rate effective for diagnostic imaging.

Since our last inspection the diagnostic imaging service had improved services including moving from mobile units to an onsite purpose-built unit.

Good

Diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

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

Mandatory training

- For our main findings please refer to the surgery report.
- Mandatory training was a mixture of face to face training and electronic learning across the department. Staff we spoke with told us they were up to date with mandatory training and managers told us that compliance was 92%. Managers told us that where mandatory training was not complete, staff were booked in to complete mandatory training.
- The hospital provided a mandatory training compliance document showing compliance as at 9 September 2018. This showed compliance levels of 80% and above for the various mandatory training modules. The target for quarter three was 75%.
- Mandatory training covered various training; for example, information governance, fire safety and infection, prevention and control.

Safeguarding

- For our main findings please refer to the surgery report.
- Staff we spoke with could describe how they would report a safeguarding concern and told us there was a hospital safeguarding lead they could contact for advice. During the inspection we saw safeguarding posters in the department on display.
- The service used a six-point check to check patient identification for example. When in the x-ray room for example, there was the PAUSE checks displayed and staff told us patient, anatomy, user checks, systems and settings and exposure (PAUSE) check was used in the scanning rooms prior to scans.
- Managers told us all radiographers were trained to level three safeguarding and that healthcare assistant staff were trained to level two safeguarding. However, the mandatory training compliance document the hospital provided did not show the level three training compliance figures. The hospital provided mandatory training safeguarding compliance levels and these showed that in September 2018 compliance for safeguarding adults level one and level two was 93% and compliance for safeguarding children level one and two was 93%. The target was 75%.
- A chaperone service was available to patients and posters were on display in the waiting area. Staff told us they could provide a chaperone.

Cleanliness, infection control and hygiene

- For our main findings please refer to the surgery report.
- Areas we visited were visibly clean and tidy. Hand hygiene audits were part of the audit document the department had. The hospital provided a quarter one hand hygiene audit for imaging and this showed compliance of 91%. The quarter two hand hygiene audit for imaging showed compliance of 100%, however the information provided did not highlight which year these were from.
- Staff we spoke with told us that where a patient attending had communicable or infectious disease they would add the patient to the end of the daily list. The cleaning team would be informed and the service could access a deep clean if required. The department could contact the hospital infection, prevention and control lead for advice and support.
- The department had an infection, prevention and cleanliness lead and there was a hospital infection, prevention and cleanliness lead to contact for advice if required. The hospital provided mandatory training compliance figures and this showed that in September 2018 compliance with infection control mandatory training for the department was 90% against a quarter three target of 75%.
- Staff we spoke with told us that when ultrasound probes had been used they were cleaned afterwards.
- We saw a 'bare below the elbow' poster on display in the imaging department.

Environment and equipment

- For our main findings please refer to the surgery report.
- The department had a resuscitation trolley available. This had been checked daily. Staff told us that each month the trolley was cleaned, date checked and tagged. An anaphylaxis kit was available in the CT room for use if required.
- There was a list of risk assessments for the department. The department had these in paper format in a folder.

Good

Diagnostic imaging

- The hospital provided a local rules document which detailed the area local rules for areas such as general radiography x-ray room and dental, area local rules for radiation safety fluoroscopy x-ray room and area local rules for radiation safety CT suite for example.
- The department had a waiting room with information such as interpreter services on display and seating was available. The main imaging department had a toilet and rooms for x-ray, ultrasound and three reporting rooms. MRI and CT had a separate waiting area and there were warning signs such as radiation and do not enter warning signs outside the rooms.
- Lead aprons were available for use and the service did an annual audit check on the aprons to check for damage on the aprons. The audit was documented on the department audit schedule. The service had completed the audit in September 2018 and staff told us this included a visual check and screening check.
- Equipment was managed through service contracts. An outsourced provider checked the diagnostic reference levels (DRL's) and carried out regular internal quality assurance, for example coils on the MRI and CT to check the slices are being done.
- Where equipment was faulty, a do not use sign was attached and the equipment was reported to be fixed.
- Equipment in the department was part of a servicing programme. Managers told us that equipment was serviced six monthly. The department had a quality assurance folder with information about the quality assurance programme.
- Managers we spoke with told us there was a separate uninterrupted power supply for the equipment in the imaging department in case of power supply interruptions.
- IT support was available from the hospital and there was a team which could be contacted at a corporate level if there were issues with the IT systems.

Assessing and responding to patient risk

- For our main findings please refer to the surgery report.
- The service used the PAUSE checks in the x-ray rooms for example and there was a six point check the service used to check identification and whether the patient had any previous x-ray for example.
- Staff we spoke with told us that if a patient deteriorated in the scanning rooms, staff would call the hospital resuscitation team, move the patient from the scanning area and if required call the emergency services. Managers told us there had been simulations of deteriorating patients in MRI and CT in the previous 12 months.
- The service had three radiation protection supervisors and had outsourced the radiation protection advisor to an external organisation. The outsourced organisation carried out the annual check for diagnostic reference levels.
- MRI and CT waiting areas had warning signs on display such as do not enter and radiation warning signs. There was a do not enter sign in the main waiting area. There were also signs regarding informing a radiographer if you could be or were pregnant in the main waiting area.
- We were told that staff could contact a radiologist for advice if required.

Nurse/Radiographer staffing

- For our main findings please refer to the surgery report.
- The service had five radiographers, four whole time equivalent and one-part time member of staff. There were three MRI and CT radiographers. The service had three healthcare assistants which were a mixture of whole time equivalent and part time staff. Managers told us that staffing levels were organised weekly to ensure each of the areas of the service were covered. Managers told us there were no current concerns with staffing levels across the imaging service.
- The imaging reception desk was staffed generally by two or three staff members.
- The service used bank staff as required. Agency staffing was not used in the imaging department.

Medical staffing

- For our main findings please refer to the surgery report.
- Medical staff were employed by other organisations in substantive posts and had practising privileges (the right to practice in this hospital).
- Medical staff would provide their availability and would be added to the rota for clinics as required.
- Agency staffing was not used in the imaging department.

Records

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

Good

Diagnostic imaging

- We checked five medical records during the inspection and these were completed as required. Records were kept on password protected system and kept electronically.
- The previous inspection found that world health organisation safety checklists was used for interventional radiology; however, was not audited. During this inspection, managers in the imaging department told us audits were carried out on the WHO checklists.

Medicines

- For our main findings please refer to the surgery report.
- The imaging department kept contrast media. This was kept in a locked medicine cupboard and medicines checked were in date. A registered healthcare professional held the keys to the medicine cupboard. An anaphylaxis kit was available in the CT room.
- The service had patient group directives (PGD) in place. These were kept in a folder and the PGD's checked were signed by a pharmacist, matron, radiographer and authorised by a member of the medical advisory committee at the hospital.

Incidents

- For our main findings please refer to the surgery report.
- There had been three radiation incidents in the previous 12 months. We were told these were not reportable incidents to the CQC. The service reported incidents to the radiation protection advisor where a decision would be made as to whether the incident was a reportable incident.
- Staff had access to an electronic incident reporting system and staff we spoke with were aware of how to report incidents. The department had implemented a morning daily huddle in September 2018 and the minutes from one of the daily huddles showed that incidents would be part of this daily huddle.
- Staff we spoke with told us learning from incidents would also be shared at team meetings and by emails to staff. The hospital provided minutes of the imaging team meeting from May 2018 and this had a section on incident review including learning outcomes.
- Managers we spoke with told us they would share learning from incidents through emails and staff we spoke with told us they did receive information about incidents through email.
- Staff we spoke with were aware of the duty of candour.

Safety Thermometer (or equivalent)

- For our main findings please refer to the surgery report.
- The safety thermometer was not used in the imaging department.

Are outpatients and diagnostic imaging services effective?

We do not rate effective in diagnostic imaging; however, we found the following during the inspection.

Evidence-based care and treatment

- For our main findings please refer to the surgery report.
- There were protocols for different areas of imaging, for example CT imaging. Staff told us these were reviewed annually. Staff we spoke with told us that evidence-based practice was shared through a central hospital team.
- Diagnostic reference levels were audited annually. DRL audits were carried out by an external provider. New guidance and information was shared with the department from the hospital governance team.
- However, we were told that discrepancy meetings were not held within the service.

Nutrition and hydration

- For our main findings please refer to the surgery report.
- Staff could provide patients with food and drink if required; for example, if transport was delayed. Staff could also offer food and drink where patients had pre-assessment diets or to diabetic patients.

Pain relief

- For our main findings please refer to the surgery report.
- Pain relief medication was not kept in the department.

Patient outcomes

- For our main findings please refer to the surgery report.
- The hospital had a clinical audit effectiveness meeting and managers we spoke with told us the imaging department would attend this meeting. However, there were no formal discrepancy meetings in the service.
- There was an audit schedule on display in the department office. This audit log included audits such as a reporting turnaround time audit for example.

Competent staff

Good

Diagnostic imaging

- For our main findings please refer to the surgery report.
- Staff we spoke with told us there were opportunities to develop and learn and some staff had completed further training to develop further in their roles. Staff we spoke with had received additional training, for example some staff had attended university courses, seminars applicable to their role and the department and some healthcare assistants were completing additional courses.
- Staff had an annual performance review carried out by the department managers. However, we did not see compliance levels for completed performance reviews.
- The department had three radiation protection supervisors. Staff we spoke with told us that IRMER updates, learning and training would be given at staff meetings and through staff e-mail.
- Managers we spoke with told us that bank staff and permanent staff attended an induction at the hospital and told us an external provider had provided IRMER update training in 2017.
- Managers told us permanent and bank staff were required to attend a hospital induction.

Multidisciplinary working

- For our main findings please refer to the surgery report.
- Different staff worked together throughout the department, for example healthcare assistants, radiographers and radiologists to provide care to patients.
- Staff had access to advice from a children's nursing team at the hospital if required.
- The service had a one-stop breast clinic service which included a mammographer, healthcare assistant and radiologist.
- Staff in the service could contact the children's team for advice if required.

Seven-day services

- For our main findings please refer to the surgery report.
- The imaging department was open Monday to Friday 8:30am to 9pm. Evening clinics were offered and there was a Saturday morning clinic each week. There was an on-call service for general x-ray.
- Computerised Tomography (CT) was provided on a Tuesday and Saturday. The MRI unit was open 7:30am to 8:30pm Monday to Friday.

Health promotion

- For our main findings please refer to the surgery report.
- Smoking cessation posters were on display in some areas of the department.
- There were signs regarding informing a radiographer if you could be or were pregnant in the main waiting area.

Consent and Mental Capacity Act

- For our main findings please refer to the surgery report.
- Managers we spoke with told us mental capacity act training was part of the hospital mandatory training. The mandatory training records provided by the hospital did not show compliance levels for mental capacity act training in the service.
- Consent was either verbally gained or written consent. Staff told us they would use written consent for interventional procedures.

Are outpatients and diagnostic imaging services caring?

Good

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

Compassionate care

- For our main findings please refer to the surgery report.
- Staff described how they provide compassionate care to patients. Staff described how they ensure privacy and dignity during visits to the department, such as using the curtains in clinic rooms and ensuring doors are closed to clinic rooms.
- We spoke with five patients during our inspection. Patients feedback was positive about the service and staff.
- Chaperones were available in the department and there were posters informing patients of chaperones in the waiting areas.
- Patients could check in at an imaging department reception which was in a separate area to the imaging department waiting room.

Emotional support

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

Good

Diagnostic imaging

- Staff we spoke with told us they introduced themselves to patients and would explain the procedures and allow time for questions from patients.

Understanding and involvement of patients and those close to them

- For our main findings please refer to the surgery report.
- Staff we spoke with told us they would explain when results would be expected and there was a poster on display in the waiting rooms regarding imaging results.
- Staff provided patients with details of who to contact after their appointments if they needed to contact the department.
- During the inspection we saw safeguarding posters in the department on display.

Are outpatients and diagnostic imaging services responsive?

Good

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

Service delivery to meet the needs of local people

- For our main findings please refer to the surgery report.
- The service was delivered to meet the needs of local people and provided a variety of services within the diagnostic imaging department.
- The department had three radiation protection supervisors and had access to a radiation protection advisor for advice. The radiation protection advisor was outsourced to a third party.
- The waiting room had a poster regarding waiting times for clinics and informed patients to let staff know if they had been waiting over twenty minutes.
- The service had a one-stop breast clinic service which included a mammographer, healthcare assistant and radiologist.
- The imaging department had a check in desk and a waiting room. Seating was available and the department had a toilet. The service generally opened Monday to Friday and there were evening clinics in some areas and a Saturday morning clinic each week.

Meeting people's individual needs

- For our main findings please refer to the surgery report.
- Interpreter services were available and there were posters in the department and waiting room informing patients and visitors of this. Staff we spoke with told us there was an infection, prevention and control lead and dementia lead staff could contact if required.
- Managers and staff told us how they accommodate vulnerable adults or people living with dementia for example. Staff would offer additional time in clinic for patients, explain the procedures and patients could visit the department before their appointment to familiarise themselves with the department. Longer appointment times could be offered for vulnerable patients.
- Staff told us chaperones were available if requested and there were posters advising patients of chaperones in the waiting area of the imaging department.

Access and flow

- For our main findings please refer to the surgery report.
- Referrals were accepted for adults and children; however, staff told us the number of children attending the department was minimal.
- We asked managers about waiting times for appointments and were told these were minimal; for example, the maximum wait for any of the services would be around five weeks. However, the service did not collate referral to treatment performance and would therefore be unable to identify if performance was deteriorating and take action to address this.
- Managers told us they were generally able to accommodate urgent scans where required in imaging. Managers told us schedules for clinics were managed weekly.
- The previous inspection found issues around consistency of reporting times for scans. During this inspection the department had audited reporting waiting times. The audit took thirty scans for CT, MRI and X-Ray and audited the average number of days it took to report the scan. The radiology reporting timeframe audit quarter one 2018 showed that the average number of days it took to report an x-ray was 2.5 days, the average number of days it took to report a CT scan was 1.6 days and the average number of days it took to report an MRI scan was 1.5 days.
- The radiology reporting timeframe audit quarter two 2018 showed that the average number of days it took to

Good

Diagnostic imaging

report an x-ray was two days, the average number of days it took to report a CT scan was three days and the average number of days it took to report an MRI scan was four days.
- The radiology reporting timeframe audit quarter three 2018 showed the average number of days it took to report an x-ray was three days, the average number of days it took to report a CT scan was one day and the average number of days it took to report an MRI scan was three days.
- The hospital provided a reporting action plan. The action plan had four actions, two for quarter two and two for quarter three. This action plan had a section for update, action taken and outcome; however, it did not detail an action completed date.
- Managers we spoke with told us there were no current issues with 'Did not attend' (DNA) appointments. The department had carried out an audit and managers told us the DNA audit for August 2018 showed a DNA rate of 0.1% and the July 2018 audit showed a DNA rate of 0.6%.
- Managers from the imaging department would attend weekly bed management meetings if available and required.
- There were posters in the waiting areas informing patients to let staff know if they had been waiting more than twenty minutes for their appointment.
- The service had a referral list which showed which professions could refer into the service.

Learning from complaints and concerns

- For our main findings please refer to the surgery report.
- Feedback from patients was gathered through a recently introduced patient satisfaction survey; however, results were not available for this as it had only recently been introduced.
- Complaints were on the agenda for the recently introduced daily huddle in the department.
- Managers and staff told us they would share learning through e-mail to the team and through team meetings; however there had been limited team meetings in the previous six months.

Are outpatients and diagnostic imaging services well-led?

Good

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

Leadership

- For our main findings please refer to the surgery report.
- The department was managed by a radiology manager. Diagnostic imaging managers reported to a hospital matron and then to a hospital director. There was a lead radiographer for MRI and CT.
- Staff we spoke with told us that managers were visible and approachable.

Vision and strategy

- For our main findings please refer to the surgery report.
- Managers we spoke with told us there was a Spire hospital strategy and there was an imaging department strategy and vision in the waiting room.

Culture

- For our main findings please refer to the surgery report.
- Staff we spoke with told us they were supported by managers and the team. Staff were positive and described morale as being good. Staff we spoke with told us there was openness and honesty.
- Staff we spoke with were aware of the duty of candour regulations.

Governance

- For our main findings please refer to the surgery report.
- There were no specific imaging department governance meetings but the imaging department were part of the hospital governance meetings. Risks, for example would be taken to the governance meeting and managers told us they had regular discussion with the hospital matron.
- Managers told us radiation protection committee meetings occurred annually and that issues from this would be taken to the governance meetings at the hospital.
- There was an action tracker for the radiation protection committee meeting minutes from January 2018 with a mixture of open and closed as the status of the action. However, there was no completion date identified for the action tracker.

Good

Diagnostic imaging

- Service level agreements were managed by the hospital business team.
- A representative from the imaging department attended the hospital daily huddle.
- There was a quality assurance schedule which included equipment such as ultrasound.
- Medical staff were employed by other organisations in substantive posts and had practising privileges (the right to practice in this hospital) and this was managed by the human resources department at the hospital.
- The hospital provided minutes of the imaging team meeting from May 2018. This had sections on incident review including learning outcomes, clinical effectiveness and risk, audits and action plans and governance and compliance for example.

Managing risks, issues and performance

- For our main findings please refer to the surgery report.
- The imaging department's risk register was electronic and had four risks attached. For example, risks included radiation risks and MRI safety. Managers told us these risks were reviewed quarterly.
- The World Health Organisation (WHO) safety checklist was in use by the imaging department and the department had started to audit these safety checklists. This had been implemented since the last inspection.
- The hospital provided the quarter one safer surgery audit for diagnostic imaging which showed compliance of 88%. The safer surgery audit for diagnostic imaging for quarter two showed 95% compliance. The hospital also provided action plans for the safer surgery audit for quarter one and quarter two. However, the information provided did not highlight which year these were for.
- The service had a risk assessment library. This contained risk assessments for lead apron wearing for example. Risk assessments were managed by the hospital health and safety team.

Managing information

- For our main findings please refer to the surgery report.
- Information was available through the hospital intranet and staff had access to the required information systems. Staff told us that systems were password protected.
- An accessible information standards poster was on display in the waiting area of the imaging department. This informed patients to let staff know if they had communication support needs.

Engagement

- For our main findings please refer to the surgery report.
- The department had started a patient satisfaction in the two weeks prior to the inspection and these surveys were available in the waiting area. There were no results currently available for this survey as it had recently started.
- An annual staff survey was completed by the hospital.

Learning, continuous improvement and innovation

- For our main findings please refer to the surgery report.
- Previously the service had a mobile scanning unit and since the previous inspection the service had implemented MRI and CT scanning in the department.
- The service had recently implemented patient surveys in the department to seek patient feedback regarding the service.
- The service had implemented world health organisation checklist audits since the previous inspection.

Outstanding practice and areas for improvement

Outstanding practice

- We saw that the service had enrolled in the 'safe place scheme' and the logo was displayed at the hospital entrance. This initiative meant that vulnerable people could identify the facility as a 'safe place' and be assured they would receive appropriate help.
- Oncology patients received individualised care with the support of an established multidisciplinary team and this was recognised through achievement of Macmillan accreditation.
- The service was awarded 'Spire Exemplar Site 2018' for its innovative approach to caring for patients with dementia and was recognised in the national press.
- The children and young people's (CYP) service provided a 24-hour telephone line that children and their parents could contact post discharge if they had any concerns about the recovery of their child. Families could also send a text message to the same number.
- The hospital provided a consultant led service for gender reassignment and staff used national guidance to support this pathway such as Interim Gender Dysphoria Protocol and Service Guideline 2013/2014 (NHS England) and Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (the World Professional Association for Transgender Health). The CYP lead demonstrated compassionate leadership and a clear understanding of the emotional needs of young people undergoing gender transition. For example, using appropriate pronouns and language to describe procedures, the importance of confidentiality, and the role of the registered children's nurse and child and adolescent mental health service (CAMHS) in supporting young people to maintain supportive friendship networks through the process.
- The CYP lead described supporting a child with a needle phobia by inviting them to visit the pathology lab, wear a child-sized white coat and meet the scientists to understand what happens to their blood samples, to reduce anxiety about the process.
- The service followed the Royal College of Anaesthetists guidance about preoperative fasting to ensure children and young people fasted for the safest minimal time possible. The hospital audited whether CYP theatre starve times were within guidelines and scored 100% compliance from January to June 2018.
- All CYP staff (100%) had completed paediatric competencies. In addition to this some diagnostics and pharmacy staff had undertaken the competencies despite this not being a requirement of their role. In total we found 56% of all staff who did not require the competencies had undertaken them. This included 92% of outpatients staff, 81% of physiotherapy staff, 45% of theatres staff and 19% of ward staff.
- Longer appointment times were allocated for children in the diagnostics department and to reduce fear, staff would x-ray the child's teddy bear and show them the x-ray picture, before x-raying the child.
- The service made adjustments and had reconfigured weekly outpatient clinics to better meet the needs of children and young people with disabilities. For example, clinics for children with learning difficulties, attention deficit hyperactivity disorder (ADHD) and Asperger's were now scheduled at the quieter Lowfield's building and held on a Saturday morning. This recognised that a busy noisy late weeknight clinic at the main hospital building was not the best environment in which to make an effective assessment of these children and young people. Staff told us that the quieter environment had led to a much-improved patient journey and positive feedback from families.
- We saw that children's procedures were booked at the beginning of theatre lists, which usually meant it was timely and children and young people could recover and return home the same day. We reviewed the paediatric admission register which confirmed this and spoke with staff who were flexible about coming in early to accommodate early lists.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The hospital should ensure that it communicates to all staff the importance of prescription charts being completed in full.
- The hospital should ensure it continues to work to improve the number of patients who have their surgery rescheduled within 28 days following cancellation.
- The hospital should ensure it continues to monitor cancellation of outpatient clinics and take action to reduce the number of cancelled / rearranged outpatient appointments.
- The hospital should ensure it continues to improve how patient outcomes and audit data are implemented, interpreted and used to improve, sustain good practice and support innovation.
- The hospital should ensure it continues the work to manage and mitigate environmental and security risks in the children's ward including ligature risks, secure access and the suitability of waiting areas for older children.
- The hospital should ensure its arrangements for the transfer of sick children to the NHS are formalised and current.
- The hospital should ensure it considers whether the children's and young people's service is sufficiently represented at senior and strategic level to influence and support a growing service.
- The hospital should ensure that all safety checks and log books for equipment, for example the difficult-intubation equipment trolley are completed appropriately.
- The hospital should ensure that action plans following audits detail comprehensive actions including detailing any subsequent actions or cooperation by other departments or disciplines.
- The hospital should ensure that work to improve FFT response rates at the hospital, is implemented.
- The hospital should ensure information is readily available in different languages or formats if required.
- The hospital should ensure it continues to work to ensure that there is evidence to provide that actions to mitigate risks, following serious incidents, are completed effectively.
- The hospital should ensure minutes of clinical governance show evidence of analysis, challenge or assurance.
- The hospital should ensure risk registers are further improved to ensure there are no long-standing risks and that all risks have evidence of actions to mitigate the risk.
- The diagnostic department should collate referral to treatment performance data to ensure any deterioration in performance is recognised in a timely manner.