Spire Healthcare Limited

Spire Dunedin Hospital

Inspection report

16 Bath Road
Reading
RG1 6NS
Tel:

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

Ratings

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

Summary of findings

Overall summary

Our rating of this location stayed the same because:

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

However:

- We found several pieces of diagnostic imaging equipment that did not have visible servicing or electrical testing safety stickers on them, so staff could not be assured of their safe use.
- The service did not always have clear overview of equipment safety and maintenance for equipment in the outpatients clinics.
- Staff in outpatients did not always dispose of medical waste appropriately.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Our rating of this service stayed the same. We rated it as good because it was safe, effective, caring, responsive and well led.
Medical care (Including older people's care)	Good 	Medical Care is 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 rated this service as good because it was safe, effective, caring, responsive and well-led.
Outpatients	Good 	Outpatients was 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 rated this service as good because it was safe, effective, caring and responsive, and well led.
Diagnostic imaging	Good 	Diagnostics and Imaging is 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 rated this service as good because it was safe, effective, caring and responsive and well led.
Services for children & young people	Good 	Children and young people's services is 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 rated this service as good because it was safe, caring and responsive and well-led. We did not rate the effective domain.

Summary of findings

Contents

Summary of this inspection

Background to Spire Dunedin Hospital

Spire Dunedin Hospital is a purpose-built private hospital managed by Spire Healthcare. The hospital provides care for private patients who are either covered by their insurance companies or are self-funding. Patients funded by the NHS, mostly through the NHS referral system can also be treated at Spire Dunedin Hospital.

The hospital has 16 private rooms, each with en-suite facilities, TV and Wi-Fi, and 8 day case beds. There are two operating theatres, both of which are laminar flow theatres for orthopaedic surgery. There is an on-site pharmacy which is open 8am to 4pm, Monday to Friday; there is also a restaurant for staff, as well as free car parking and a garden with tables and chairs, for warmer months. Patients were served in their room and visitors were also accommodated with refreshments.

The services include, but are not limited to, orthopaedics, gynaecology, general surgery, urology and ophthalmology. All patients are admitted and treated under the direct care of a consultant and medical care is supported 24 hours a day, seven days a week by an onsite resident medical officer (RMO). Patients are cared for and supported by registered nurses, healthcare assistants and allied health professionals such as physiotherapists who are employed by the hospital. At the time of our inspection, there was a hospital director and interim director of clinical services.

We last inspected the service in 2016.

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.

How we carried out this inspection

During the inspection, we assessed the surgical, medical, children and young people, outpatients and diagnostics imaging services. We reviewed the overall governance processes for the hospital and report on this as part of the well-led domain. We spoke with 50 members of staff including registered nurses, healthcare assistants, reception staff, medical staff, operating department practitioners, facilities staff and senior managers. We spoke with nine patients and observed six patient care and procedures with the consent of the patients.

We looked at patient waiting areas and clinical environments, attended staff huddles, looked at 24 patients' care and treatment records, and at hospital policies, procedures and other documents relating to the running of services.

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

Areas for improvement

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

Action the service SHOULD take to improve:

Summary of this inspection

Outpatients

- The provider should ensure that staff adhere to the guidance on safe disposal of medical waste and appropriate use of sharps bins. (Reg 15 (1)(a))
- The provider should ensure that staff adhere to the guidance on safe care and treatment regarding personal protective equipment. (Reg 12 (2)(h))
- The provider should ensure staff are adhering to guidance and legislation with regard for consent. (Reg 11 (1)(3))
- The service should consider the monitoring of cancellations and the process for following up patients that did not attend appointments
- The service should ensure clear oversight of equipment servicing and maintenance and that any equipment labels are up to date (Reg 15) (1)(e))

Action the service SHOULD take to improve:

Diagnostic Imaging

- The service should ensure clear oversight of equipment servicing and maintenance and that any equipment labels are up to date (Reg 15) (1)(e))

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Medical care (Including older people's care)	Good	Good	Good	Good	Good	Good
Outpatients	Good	Inspected but not rated	Good	Good	Good	Good
Diagnostic imaging	Good	Inspected but not rated	Good	Good	Good	Good
Services for children & young people	Good	Inspected but not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Surgery

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

Are Surgery safe?

Good

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

Mandatory training

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

Nursing staff received and kept up to date with their mandatory training. There were 15 mandatory training modules to be completed annually, with a target for all teams of 95%. In March 2022, compliance rates among the surgery team (which included theatre, pre-operative assessment and ward staff) were 99% for all modules. Only one module, resuscitation, was below target at 86% though a new electronic simulator had recently been introduced to help recover the shortfall caused by face to face training having been more challenging due to social distancing requirements. The training year ran to the end of March 2022, meaning there was over a month for the remaining staff to complete their mandatory training. The service gave assurance that the target would be met hospital wide.

In order to tackle the impact the pandemic had on training, the service had also recently introduced a simulator programme for BLS (basic life support) and PBLS (paediatric basic life support) training which all clinical staff completed quarterly.

Medical staff completed mandatory training via their employing NHS trust. The agency Resident Medical Officers (RMO) completed their mandatory training through their agency and at Spire on induction.

The mandatory training was comprehensive and met the needs of patients and staff. Training included infection control, safeguarding and manual handling.

Managers monitored mandatory training and alerted staff when they needed to update their training. Mandatory training was a standard agenda item at the team meeting and minutes confirmed this.

Safeguarding

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

Good

Surgery

All staff received training specific for their role on how to recognise and report abuse.

As at March 2022, adult safeguarding training up to level 3 had been completed by 100% of pre-operative assessment, theatre and ward staff. Safeguarding children training up to level 3 had also been completed by 100% of pre-operative assessment, theatre and ward staff. The end of year training target of 31 March 2022 was 95% compliance.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Safeguarding adults and children policies were in-date and accessible to all staff. There was a flow-chart which included local leads and contact details for the local authority safeguarding teams.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could give examples of what a safeguarding concern would be and knew who to contact for support. The safeguarding leads, including their photographs were displayed on noticeboards in theatre and on the wards.

Cleanliness, infection control and hygiene

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

The hospital had infection control policies and procedures to help control infection risk. These and other related policies covered the actions required by staff to minimise the risk of infection and cross infection in the hospital and the surgery service. In addition, new protocols and procedures had been produced in response to the COVID-19 pandemic. This included a new procedure for when staff, patients and visitors arrived at the hospital, and for patients who needed to home isolate and have a negative COVID-19 test before their elective surgery.

COVID-19 was still a risk when the inspection took place and therefore COVID-19 measures were in place at the hospital. During our inspection we saw COVID-19 measures carried out to protect patients, visitors and staff, such as face masks available at the entrance to the hospital, rapid lateral flow tests available to test day patients and visitors for COVID-19 at the entrance, hand sanitiser available at the entrance and throughout the hospital, signs to remind patients, visitors and staff of the need for social distancing to reduce the spread of the virus, and posters highlighting the importance of good hand hygiene.

Staff could explain the procedures they would follow if they had concerns about a patient or visitor's infection status.

All areas of the surgery service we inspected, including the theatres and wards, were visibly clean and tidy. We saw suitable flooring and furnishings throughout the hospital and the surgery service.

The hospital had housekeeping staff who were responsible for cleaning patient and public areas, in accordance with daily and weekly checklists. Cleaning records were up-to-date and demonstrated areas were cleaned regularly and deep cleaned when needed. Cleaning equipment was stored securely in locked cupboards. This meant unauthorised persons could not access hazardous cleaning materials.

Staff used I am clean stickers on equipment in the clinical areas to identify that items had been cleaned and were ready for use.

Good

Surgery

Staff were required to complete infection, prevention and control (IPC) training during their induction and then annually at the level appropriate to their role as part of their mandatory training. We observed staff following good general infection control practices to minimise the spread of any infection; they wore face masks, were bare below the elbow and cleaned their hands before and after contact with every patient. Staff had access to hand washing facilities and personal protective equipment, such as gloves and aprons in a variety of sizes. Clinical handwashing sinks were installed in clinical areas in the theatre suite and on ward corridors and in patients' bedrooms. This meant staff had the facilities needed to effectively wash their hands to help prevent avoidable health acquired infections.

There were effective systems to ensure standards of hygiene and cleanliness were regularly monitored, and results were used to improve IPC practices if needed.

The service performed well for cleanliness. IPC audits completed included environment, hand hygiene, bare below the elbow and PPE. The audit programme was used to increase and maintain standards and help prevent the spread of infection. IPC was discussed during ward and theatre meetings and issues were raised and an action plan put in place. Results for the first quarter of 2022 were all above 95% compliance. All staff were required to complete IPC training annually and the deadline was 31 March 2022. As of March 2022, the completion rates were 100% for pre-operative assessment, ward and theatre staff.

The hospital completed water flushing round the hospital. We reviewed documentation that showed that regular water testing was being carried out.

Nursing staff carried out infection control risk assessments on all patients as part of their pre-admission assessment process. This included details about any recent illnesses; MRSA status and possible exposure to MRSA or infectious diseases in the month before pre-admission screening. This facilitated the identification of infection risks at the earliest possible time in the patient's care pathway to ensure correct infection prevention and control practices were instigated.

The service provided patients with verbal and written information, in their pre-admission information pack and on discharge from the hospital, on how good IPC measures prevented and controlled infection. It included information about hand washing and caring for surgical wounds. This also included information for the patient on how to spot the signs and symptoms of a wound infection and what action needed to be taken if a patient had concerns.

The hospital had two laminar flow operating theatres, a system of circulating filtered air to reduce the risk of airborne contamination. This worked to prevent airborne bacteria from getting into open wounds, as well as removing and reducing levels of bacteria on exposed surgical instruments.

Staff followed good practice guidance and maintained clean and dirty flow within the operating theatres. This included limiting the number of staff entering the operating theatre during surgery and restricting the movement of personnel in the operating theatre to a minimum.

The hospital had recorded no surgical site infections (SSI) in the previous 12 months. The hospital reported no incidences of *c.difficile*, methicillin sensitive staphylococcus aureus (MSSA) and MRSA in the past 12 months.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw the correct use of (PPE) such as disposable gloves, aprons and masks. PPE was available in all clinical areas. Staff in theatres wore

appropriate theatre clothing (scrubs) and designated theatre shoes were worn. This was in line with best practice (Association for Perioperative Practice (AfPP), Theatre Attire (2011). Staff followed the hospital's policy on infection control, for example, we observed staff complying with 'arms bare below the elbow' and not wearing jewellery. Face masks were worn by all staff, which was in line with COVID-19 guidance.

Staff worked effectively to prevent, identify and treat surgical site infections. There were systems to prevent and protect people from a healthcare associated infection and ensure standards of hygiene and cleanliness were maintained. This was in line with current guidance from the National Institute for Health and Care Excellence (NICE) Quality Standard (QS) 61: Infection Prevention and Control (April 2014).

Environment and equipment

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

The design of the environment followed national guidance.

The ward environment and equipment were clean and free from dust. Inpatient rooms were clean and tidy. The operating theatre layout was clutter free. Staff carried out daily safety checks of specialist equipment.

Emergency equipment for the wards was stored in the corridors with clear access. Records indicated that the resuscitation trolleys and their contents were checked daily in line with hospital policy. The trolleys were secured with tags which were removed monthly to check the entire contents were in date. Items had details of service date on them and were dated for next service. Theatres also had a difficult airway trolley which was checked daily.

We found medical gas cylinders securely stored against the wall in a separate area, labelled and checked. In recovery there was a transfer bag which had been checked. The emergency drug box and anaphylactic box were labelled and sealed. On both the ward and in theatres there were posters displayed with the locations of other emergency equipment. Fridge temperatures were checked daily and within range.

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

There was an equipment register and loan equipment was available if required. There were bariatric chairs and commodes if needed. Ward areas were clean and had suitable furnishings which were clean and well-maintained.

The hospital also recorded implants used on national registers, such as the breast implant register and national joint register (NJR). This showed which patient received which type of implant and when, to allow tracking if needed.

We witnessed staff disposing of clinical waste safely. We also inspected the dirty utility rooms in the ward and theatres and found them to be visibly clean and all labelled correctly in line with national guidance.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

Good

Surgery

The National Early Warning Score (NEWS2) was used to identify deteriorating patients. Staff recorded routine physiological observations, such as blood pressure, temperature, and heart rate, all of which were scored according to pre-determined parameters. We reviewed 10 records during this inspection and found all had NEWS completed correctly. NEWS audits for the past 12 months showed over 90% compliance.

Staff told us that if a patient's NEWS score indicated they were deteriorating they would escalate it to the nurse in charge.

Further, there was a designated resus team allocated to respond to any emergency every day at the resus huddle who also had support from the RMO (Resident Medical Officer) 24 hours a day, seven days a week, who was ALS (Advanced life support) and EPLS (European Paediatric Advanced Life Support) trained.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. All NHS referrals went to the director of clinical services or clinical governance lead first to confirm that the procedure met their criteria, before going to the pre-operative assessment (POA) team. There was a new electronic pre-operative assessment (EPOA) system which was being implemented across Spire hospitals. There was a flow chart for staff to follow and if they had significant concerns a multi-disciplinary (MDT) meeting would be held. This was also documented in the patient records we reviewed. We saw evidence of this being requested in the notes we reviewed. The hospital held weekly planning meetings with the interim director of clinical service, pre-operative assessment, theatre staff, ward manager, physiotherapy and pharmacy to discuss all surgical admissions for the following week to review care needs.

Staff knew about and dealt with any specific risk issues. Nursing staff used nationally recognised tools to assess patients' risk of, for example, developing pressure ulcers (Waterlow), malnutrition (malnutrition universal screening tool (MUST)), falls, infection control, and risks associated with moving and handling. We saw these had been completed in all 10 sets of notes we reviewed.

National guidance states all surgical patients should be assessed for risk of venous thromboembolism (VTE) (a condition in which a blood clot forms most often in the deep veins of the leg, groin, arm, or lungs) and bleeding as soon as possible after admission to hospital or by the time of the first consultant review. Staff completed VTE risk assessments daily and correctly for all patients in the records we reviewed. Staff also completed a monthly VTE audit and compliance for the past 12 months was at 100%.

Sepsis is a serious complication of infection. Early recognition and prompt treatment have been shown to significantly improve patient outcomes. Staff received training in sepsis management and all patient rooms had a sepsis screening tool assessment sheet. There was a sepsis trolley on the ward which contained the equipment and medicines staff needed to treat sepsis.

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

The hospital had a transfer agreement in place with the local acute NHS trust should a patient require a higher level of care. Patient notes were given to the ambulance staff with a transfer handover sheet.

Nursing staff completed a discharge summary letter for the patient's GP which could be sent via an online system or for the patient to take to their GP.

Shift changes and handovers included all necessary key information to keep patients safe.

Good

Surgery

The theatre team held a 'huddle' at the beginning of every day. These meetings were documented for staff to refer to. Ward staff held early morning handovers from the night staff to the day staff. These ensured the safe handover of patients and allocation of work was completed. During our inspection, we observed a crash huddle in which the resus team roles were allocated. These were held every morning, attended by the RMO, resus lead and ILS (immediate life support) team.

Staff completed the World Health Organisation (WHO) surgical safety checklist pathway and were fully engaged. All staff within the operating room completed the required processes in line with WHO, handover to the recovery nurse was also performed as per recommended guidance.

Swabs and instrument checks were completed correctly. The service audited WHO checklist compliance and results showed the past 12 months at 100%.

Staff had support from the RMOs if a patient's health deteriorated. An RMO was on duty 24 hours a day and was available on site to attend any emergencies.

The RMOs were able to contact the consultants for further support including out of hours. They had contact details for each speciality provided at the hospital if they could not reach the surgeon who had done the procedure.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe.

Data we reviewed, and observations made during our inspection confirmed there was enough staff to provide the right care and treatment. The service had also recruited additional healthcare assistants.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

Theatre planning meetings took place weekly and ensured that the rotas were reviewed for the following week. The operating department used guidance set out by the Association for Perioperative Practice (AfPP) related to safe staffing levels. Theatre lists were planned in advance and staffed accordingly. There were opportunities to escalate staffing concerns at the daily huddle. On call staff were allocated.

The service had implemented a safe staffing audit tool which was used on a daily basis to identify any staffing concerns to escalate to management. Staff told us they were all aware of it and felt it was helpful. Staffing was reviewed the day before and escalated to the director of clinical services if agency cover was required. Staff told us that if they had a particularly unwell patient, additional staff could be requested.

The ward manager could adjust staffing levels daily according to the needs of patients. The number of nurses and healthcare assistants matched the planned numbers. The hospital reported 100% of shifts were filled in the past 12 months.

The service had average vacancy rates. There were no vacancies for the ward or the pre-operative assessment unit, and three vacancies in theatres. Across the three surgery departments, vacancy rates were at 26%.

The service reported average sickness rates. It was 6% across the ward, the pre-operative assessment unit and theatres.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The service had low rates of bank and agency nurses. For the past 12 months, bank and agency usage in pre-operative assessment and wards was an average of 3.3 FTE (full term equivalent) per month, and 3.17 FTE per month average in theatres. The total average bank and agency usage for the previous 12 months was 6.5 FTE. Heads of department were encouraged to liaise with other departments to arrange cover before escalating to the director of clinical services to request agency cover. There was a system used which helped request agency staff that were familiar with the hospital.

Agency staff received an induction on the day. There was an agency induction checklist. We reviewed staff files and found that it had been completed in line with internal policies.

Medical staffing

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

The service had enough medical staff to keep patients safe.

Patient care was consultant-led. Consultants were available for advice and to review admitted patients and provided 24-hour on-call cover for patients post-operatively. Staff told they had no problems reaching them and that it was mandatory for all admitting consultants to visit their patients at least once per day, which the consultants did. There was a list for those on annual leave and cover detail. Consultant daily visits were audited, and compliance for the past 12 months was 100%. We were told that if a consultant did not visit their patient in a 24-hour period, it would be reported as an incident to ensure it was escalated and included in each consultant's annual appraisal and biennial review.

Consultants led and delivered the surgical service at the hospital under practising privileges. The hospital had granted 160 consultants/health professionals practising privileges, including but not limited to; specialist surgeons such as orthopaedic, ear nose and throat and urology, and anaesthetists.

There was a Spire Healthcare practising privileges and appraisal policy. The policy set out the requirements for each consultant to ensure good care and keep people safe.

All consultant surgeons, paediatricians and anaesthetists had to complete an application for admitting rights. This information was used by the hospital management team to determine whether the person had the required skills and experience to carry out treatments at the hospital. Consultants had to demonstrate they were able to perform the procedures included as part of their practising privileges and they were working within their normal scope of practice.

There were robust processes in place for reviewing practicing privileges at the hospital. The director of clinical services and the hospital director reviewed them every two years, and certain information such as mandatory training and appraisal information were reviewed yearly.

The hospital had a medical advisory committee (MAC) whose responsibilities included ensuring new consultants were only granted practising privileges if deemed competent and safe to practice. All consultants carried out procedures within their scope of practice within their substantive post in the NHS.

Good

Surgery

Immediate medical support was available 24 hours a day, seven days a week. This was covered by two RMOs who worked seven days on, seven days off. The RMOs are doctors responsible for the care of the patients in the absence of the consultant. They provided support to the clinical team in the event of an emergency or with patients requiring additional medical support. The RMOs were trained in advanced life support and held a bleep for immediate response, for example, in the case of a cardiac arrest. Nursing staff told us the RMOs were approachable and responsive when required.

Records

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

Patient notes were comprehensive, and all staff could access them easily. Records were predominantly on paper. We reviewed ten sets of notes during our inspection and found they were legible, up-to-date and contained all relevant information regarding patients' care and treatment.

Staff used specific care pathway paperwork for each patient which ensured they kept the relevant records for that procedure. Records contained information from when a patient had been booked for a procedure until follow up care after discharge had finished. Records were multidisciplinary, meaning each clinical team wrote in the same set of records, including the surgical team.

We reviewed 10 sets of patient records and found these to include the relevant assessments of care needs, risk assessments and were patient centred and personalised. Each record contained a sepsis pathway, ready for use if required. Records seen were accurate, comprehensive and provided a clear picture of the care and treatment each patient received from their initial contact through to discharge.

We saw evidence in the patient records of ward to theatre handover and theatre checklists completed. When patients transferred to a new team, there were no delays in staff accessing their records. This ensured continuation of patient care between the teams.

Records were easily available to staff providing care, stored securely and locked away when not in use. This meant there was restricted access to prevent unauthorised access to confidential patient care records. Theatre staff maintained a log of implants on their prosthetics register to enable traceability if an incident occurred. Theatre personnel retained a sticker from each implant in the register as well as in the patient notes. This meant they could clearly be tracked and traced.

Discharge letters were sent electronically to the patients' GPs immediately after discharge, with details of the treatment, including follow up care and medications provided. This ensured continuation of patient care.

Once patients were discharged and no further follow up care was required, records would be retained and stored securely within the medical records department. This department had responsibility for filing, storing and maintaining an adequate medical record for patients treated. Staff within this department ensured medical records were readily accessible for each episode of patient care and tracked throughout the hospital.

Medicines

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

Staff followed the hospital's policies and procedures when prescribing, administering, recording and storing medicines. The service had a comprehensive medicines management policy, which covered obtaining, prescribing, recording,

handling, storage, security, administration and disposal of medicines. Medicine records were completed appropriately – including allergies and VTE assessments. The hospital had its own pharmacy with their staff being responsible for the supply and top-up of medicines used in the theatre area and inpatient wards and take home medicines for patients. Nursing staff told us pharmacy staff provided a good service and were available and accessible when needed.

A pharmacist was on site between 8am and 4pm Monday to Friday and on-call to provide advice and support on evenings, weekends and bank holidays. A pharmacist was on call 24 hours a day, seven days a week to provide an out of hours service when required to support staff. The on-call pharmacist was contacted for any controlled drugs (CD) if this was required out of hours.

Medicines were stored appropriately in locked cupboards on the wards and in the theatre area. We checked a selection of medicines in the surgery service and found all were in date and kept in line with manufacturers advice. Stock matched the records. Fridge temperatures were recorded daily, and staff sought advice from the pharmacy team when the temperatures were found to be outside recommended ranges.

CDs were stored securely. The CD register reflected any CD administered and had two signatures recorded as required. Stock matched the register. Staff carried out daily checks of their CD stock and records were clearly maintained. Staff were clear and knowledgeable about the managements of CDs. We observed staff dispensing and administering a CD for one patient. They ensured the CD register was signed only after this had been administered which was in line with best practice.

The hospital used patient group directions (PGD) in line with national guidance. A PGD provides a legal framework that allows some registered health professionals to supply and/ or administer a specified medicine(s) to a pre-defined group of patients, without them having to see a doctor.

Medicines prescribed on the medicine chart were dated and signed by the prescriber. Prescriptions detailed the dose and the time the medicine needed to be administered. Nurses signed to demonstrate they had administered the medicine to the patient. Staff reviewed patients' medicines regularly and provided specific advice to patients about their medicines. The resident medical officer (RMO) sought advice from the consultant surgeon or anaesthetist before changing any patient's medicine as the consultant had overall responsibility for the patients' care.

The pharmacy team completed medicine audits, for example prescribing appropriate medicines, and turnaround time of drugs required at discharge. The team shared audit results with the departments to decide on setting up action plans if needed. Latest storage and security of medicines audits indicated compliance above 80% for the recovery, theatres and ward areas, which met the hospital target.

Medicines that needed to be kept below a certain temperature were stored in locked fridges. Ambient and fridge temperatures were checked daily and stored within the correct temperature range. Staff knew what to do if temperatures were out of range. All medication checked was in date.

Pharmacy attended multidisciplinary team meetings across the hospital.

Incidents

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

Good

Surgery

All incidents were reported in line with the Spire Healthcare incident reporting policy. The policy included definitions of incidents and their level of harm and how incidents should be reported, investigated and actions taken. Staff raised concerns and reported incidents and near misses in line with provider policy.

The hospital used an electronic system for reporting incidents. All staff could access the incident reporting system. Staff said they knew what constituted as an incident and were encouraged to report incidents or near misses so that effective measures could be taken to minimise ongoing risk to people or the organisation. There was a no-blame culture and staff said they felt confident in reporting incidents. Spire Dunedin Hospital had zero never events and severe harm incidents reported between 1 February 2021 to 31 January 2022.

The service had zero never events in the past 12 months. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. Staff reported serious incidents clearly and in line with provider policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. 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 received feedback from investigation of incidents, both internal and external to the service. The governance lead collated and shared learning from incidents with all department heads at the daily 10 at 10 meetings and shared with all staff in the weekly updates. Incidents were also a standard agenda item on the monthly ward meetings.The ward manager regularly shared information with the team via emails and the staff noticeboard. There was also a daily huddle to share information. Updates from Spire were received via the 48-hour flashes. Staff met to discuss the feedback and look at improvements to patient care. We saw evidence that changes had been made as a result of feedback.

The discharge process was adapted to include a final check of patients' rooms following an incident where a patient left their own medication behind.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Incidents were reported on an electronic incident reporting system and allocated to the department or area to investigate. Any immediate actions identified would then be completed. They were reviewed at the monthly clinical effectiveness and quarterly governance meetings. We reviewed five incident report forms and found them to be compliant with internal policies and national guidance.

Managers debriefed and supported staff after any serious incident.

Are Surgery effective?

Good

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

Good

Surgery

Evidence-based care and treatment

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

The service had up-to-date policies and procedures to ensure care and treatment was delivered in line with national guidance and best practice. Policies referenced national guidance including the National Institute for Health and Care Excellence (NICE), The Royal College of Surgeons' Standards for consultant led surgical care and the recommendations from the Association of Anaesthetists of Great Britain and Ireland (AAGBI).

For instance, staff followed guidance for surgical site infection prevention and treatment in line with NICE guideline (NG125) and in the operating theatres, staff monitored patients' temperatures in line with NICE Clinical Guideline CG65 for hypothermia.

Updates to policies, due to change in guidance and tracking of policy review dates, were carried out at a corporate level and cascaded to the hospital for implementation. Changes to policies was a standing agenda item at the hospital's quarterly clinical governance meeting. Changes in working practice was the responsibility of the head of department to execute and staff were required to sign to say they had read the update to the policy. Changes to policies and procedures was also a standing agenda on the medical advisory committee (MAC) meeting. Staff could access policy documents on the hospital's database. These measures ensured staff working in the service were following up-to-date practices and providing safe care to patients.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Awareness of the requirements of the acts was included in mandatory training.

The hospital completed a range of audits throughout the year to ensure healthcare was provided in line with their policies, national guidance and standards. This included the Spire Healthcare audit programme, a rolling programme of set audits and hospital specific audits. Audit results were collated and used to benchmark against the other hospitals of a similar size within the Spire Healthcare Group. Staff followed guidance regarding the recording and management of medical implants, such as hip implants. Patients signed a consent form agreeing they were satisfied for their details to be stored on the central database. Relevant paperwork was completed at the time of insertion of the implant and was documented in the National Joint Registry (NJR) by theatre staff. We reviewed NJR participation and outcome figures and saw that consent compliance was at 86% from November 2020 to October 2021, and at 100% from August to October 2020. Linkability rates indicate the number of records linked using National Patient Identifiers. The service reported 90% from June to August 2020, and 93% from September 2020 to August 2021.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Food was prepared on site in the hospital kitchen and met the nutritional requirements of patients, staff and visitors to the hospital. Nursing staff asked patients about any food intolerance or allergies as part of their pre-assessment. This also included specific dietary or cultural requirements, such as vegetarian, vegan gluten free or halal. This information was passed to the catering team so suitable food could be provided for the patient during their stay.

Good

Surgery

Feedback from patients relating to meals was positive. All patients we spoke to told us the food was excellent.

Patients were advised about pre-surgery fasting times (omitting food and fluids except water before operation) during the pre-assessment process. The service followed the Royal College of Anaesthetists guidance about pre-operative fasting to ensure patients fasted for the safest minimal time possible. Written information about pre-surgery fasting times was also sent to the patient. The service offered patients staggered admissions to ensure they did not fast for longer periods than necessary.

The hospital monitored patient fasting times as patients fasting for longer times than required could affect their wellbeing and the outcome of their surgery. Staff fully and accurately completed patients' fluid and nutrition charts where needed. In line with national guidance, staff used a recognised screening tool to monitor patients at risk of malnutrition, called the Malnutrition Universal Screening Tool (MUST). MUST assessments were complete in all the records we reviewed.

Staff ensured there was effective management of nausea and vomiting. They would offer anti-sickness medication for patients who reported feeling nauseated, check it had worked and if necessary, offer an alternative anti-sickness medicine.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. There was a pain assessment tool for use with non-verbal patients.

Patients received pain relief soon after requesting it. All 10 patient records we reviewed reflected that staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

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

The hospital monitored any unplanned transfers of care to another hospital, readmission to the hospital and returns to theatre. Spire Dunedin Hospital had 13 patients transferred out for clinical reasons from the ward from 01 February 2021 to 31 January 2022.

The service participated in relevant national clinical audits.

The hospital submitted Patient Related Outcome Measures (PROMS), which helped the NHS measure and improve the quality of care patients experienced during and after elective surgery. Spire Healthcare ceased collecting patient reported outcome measures (PROMs) data during 2020 due to the COVID-19 pandemic, but it recommenced from March 2021. Data for 2021 was not available.

Good

Surgery

There were systems in place to ensure that data and notifications were submitted to external bodies as required. The hospital submitted data to the Private Healthcare Information Network (PHIN). The hospital also entered information onto registers such as the National Joint Registry (NJR). Information was collected on all replacement operations and monitored; these registries ensured all medical device implants could be traced if concerns were raised about the quality or possible adverse effects. This allowed for longer term national reporting of outcomes.

Outcomes for patients were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve patients' outcomes.

Venous Thromboembolism (VTE) risk assessments were regularly audited for completion. Results from the past 12 months showed 100% compliance.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The hospital had a comprehensive audit schedule covering all clinical areas. Completed audits included action plans to address any concerns. Audits were discussed at the monthly clinical audit and effectiveness meetings.

Managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits. Audit updates were a regular item on the ward meeting agenda and displayed on the ward.

The clinical scorecard enabled the hospital to benchmark its clinical performance indicators against other Spire Healthcare hospitals. The scorecard was shared widely each quarter with each hospital. Each hospital had an action plan which was reviewed periodically by the central clinical team, and locally through clinical effectiveness meetings.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Staff completed a variety of mandatory and role specific training. Competencies were required for each role and included sepsis, transfer and VTE. Competencies were recorded in a file for each member of staff.

The role of the Medical Advisory committee (MAC) included supporting the hospital senior managers to ensure that all consultants were skilled, competent and experienced to perform the treatments undertaken. Practising privileges were granted for consultants to carry out specified procedures using a scope of practice document, these were reviewed annually. Registration with the General Medical Council (GMC), the consultants' registration on the relevant specialist register, disclosure barring service (DBS) check and indemnity insurance were all checked by the hospital and ratified by the MAC. An email was automatically generated to remind a consultant if for example their appraisal or indemnity was overdue or expired.

Resident Medical Officers (RMO) had their competencies assessed, mandatory training provided and updated and annual appraisals by Spire. They worked in line with guidelines and a handbook to ensure they were working within their sphere of knowledge.

Managers gave all new staff a full induction tailored to their role before they started work. Managers supported staff to develop through yearly, constructive appraisals of their work. The only staff who had not received an annual appraisal

were either on maternity leave, long term sick or new starters. At the time of our inspection, the hospital completion rate for appraisals was 81%. The deadline for all remaining staff was the end of March 2022. Staff told us they found the appraisal helped with progression and they were encouraged to pursue interests such as leading in particular areas. Managers made sure staff attended team meetings or had access to full notes when they could not attend. Ward meetings were held monthly and minuted.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us they had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. During the pandemic, the hospital worked with the local trust to take extra patients for surgical procedures.

MDT meetings could be triggered at any time. Theatre planning meetings happened weekly to discuss each patient, attended by the director of clinical services, ward, theatre and pre-operative assessment managers, pharmacy and physio. If anyone had concerns about a patient, an MDT meeting could be requested. The pre-operative assessment team would arrange the meeting which would be attended by the director of clinical services (DCS), anaesthetist, ward and theatre staff. These meetings were minuted and the decisions documented in the notes. We saw evidence of this in the records we reviewed.

Staff worked across health care disciplines and with other agencies when required to care for patients. Patients were advised of their potential length of stay at the pre-operative assessment. A board in the patients' rooms was updated throughout their stay. The aim was for patients to be discharged in the mornings. Pharmacy was advised and relatives were informed. Elderly or vulnerable patients would be kept in, rather than being discharged in the evening. Any delayed discharges were reported at the daily 10 at 10.

GPs were advised of discharges via an online system, or a copy was printed, and the patient asked to give it to their GP. Consent was obtained from patients before sharing with GPs.

Seven-day services

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

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

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Consultants were always on-call for patients under their care. Patients were seen daily by their consultant, including weekends. If the consultant was not available, they arranged cover by another consultant. The ward had a list for those on

annual leave and cover detail. The RMO and ward staff had a list of contacts for all consultants and anaesthetists for each patient. Staff told us medical staff could be easily contacted when needed. Anaesthetists were available via an on-call rota if a patient needed to return to theatre. There was 24-hour RMO cover in the hospital to provide clinical support to patients, consultants and staff.

The pharmacy was open from 8am to 4pm Monday to Friday, and there was an on call service out of hours and over the weekend and bank holidays. Out of hours there was an on-call pharmacist for support. If a patient required medicines out of hours, these were dispensed by the RMO. If controlled drugs were needed, the on-call pharmacist would attend the hospital to dispense them.

Health promotion

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

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

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patient records we reviewed showed consent was obtained in accordance with hospital policy.

We were told patients who were booked for cosmetic surgery were given a two-week cooling off period before undergoing the procedure, in case they wanted to change their mind. This was in line with national guidance.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff told us the majority of admitted patients had the capacity to make their own decisions. Patients who lacked capacity were identified during the pre-operative assessment process. If a best interest decision had to be made, this would be with the consultant, but these were rare.

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

Staff clearly recorded consent in the patients' records. A monthly audit showed 100% compliance for the past 12 months with the completion of consent forms, including detail of the risks and benefits of surgery and forms being re-signed on admission where consent has been obtained in advance.

Good

Surgery

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. There was an up-to-date consent policy for staff to follow. They told us they would go to the director of clinical services for advice.

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment.

Are Surgery caring?

Good

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

Compassionate care

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

Staff throughout the surgery service put patients at the centre of what they did. We saw staff treat patients with warmth and care, they were polite, professional and demonstrated compassion to all patients.

Theatre staff offered caring and compassionate care, safeguarding the patients' dignity including when they were not conscious. For example, theatre staff ensured that patients were not left exposed unnecessarily.

Staff were discreet and responsive when caring for patients. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients. Peoples' privacy and dignity was always considered. Staff always knocked before entering a room.

All four patients we spoke with during our inspection commented positively about the care and treatment they had received.

The hospital monitored patient feedback from their patient satisfaction survey and the NHS Friends and Family Test (FFT). The FFT is a tool that gives people that use the service the opportunity to highlight both good and poor patient experience. The PLACE score for September 2021 was at 91%. The patient satisfaction survey for the past 12 months showed 95% of patients rated their care as excellence and 97% of patients who completed the survey felt they were in safe hands.

Emotional support

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

When talking to staff, it was clear how passionate they were about caring for their patients and how they put patients' needs at the forefront of everything they did.

Good

Surgery

Staff working in the surgery service showed sensitivity and support to patients and those close to them. Staff understood the emotional impact of them having surgery. Staff told us they sometimes saw patients who appeared anxious due to the nature of their visits. They understood the need to give patients appropriate and timely support and information to cope emotionally with their care, treatment or condition. We observed this during the inspection.

Staff gave emotional support to patients. They understood that each patient was an individual and took time to get to know their patients. This meant they could give the right emotional support for that patient when needed. Staff told us the care and support they gave to patients had increased as currently visitors were being restricted into the hospital due to the COVID-19 pandemic. Staff were aware this could lead to patients feeling isolated and vulnerable. Where it was in the best interests of the patients, such as a patient with additional needs, visiting was still being permitted.

The service offered a chaplaincy service who could offer emotional, psychological and spiritual support to patients, relatives and staff of all, any or no faith. We saw posters telling people of this service on notice boards. The ward had a quiet room which provided patients with a quiet space if needed.

The patient satisfaction survey for the past 12 months showed 94% of patients felt staff understood their needs and 95% of patients felt staff were attentive.

Understanding and involvement of patients and those close to them

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

Patients told us they felt involved in the planning of their care. They told us they had received full information about their diagnosis and treatment and the care and support which would be offered following the procedure. Staff provided written information to support the verbal information given.

Patients told us staff clearly explained the risks and benefits of treatment to them before admission. Patients we spoke with told us they had opportunity to ask questions about their treatment. This meant that patients were involved in making shared decisions about their care and treatment.

Patients and staff told us that costs and payment methods were discussed with patients before admission and written information was provided.

The patient satisfaction survey for the past 12 months showed 91% of patients felt they were fully informed, 95% of patients were satisfied with their experience with the treatment and 91% of patients felt discharge was organised and efficient.

Are Surgery responsive?

Good

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

Service delivery to meet the needs of local people

Good

Surgery

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

Managers planned and organised services to meet the needs of those who chose to use the service. Admissions to the surgical ward were all elective and planned in advance. The hospital had admission criteria, and a dedicated admissions policy which meant the hospital only admitted patients they had facilities to care for.

Most patients who attended the hospital were privately funded or insured patients. In addition, the hospital also participated in the NHS e-Referral Service for certain procedures. Through this service, NHS patients who required an outpatient appointment or surgical procedure were able to choose both the hospital they attended and the time and date of their treatment.

The hospital had supported the local health community during the COVID-19 pandemic. They had worked closely with the local clinical commissioning group (CCG) and NHS trust to provide a range of services and specialities. This included identifying how the hospital could be used to provide COVID-19 safe environments to services that had been paused at the local trust. Feedback from the local trust was positive and mentioned how safe patients felt having their treatment at the hospital and how the logistics ran smoothly. Some of the staff in the surgery service had worked at their local trust during the pandemic and the team were proud of this.

Meeting people's individual needs

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

Staff completed equality and diversity training annually as part of their mandatory training. At the time of our inspection training compliance across staff working in the surgery service was 93%. Staff gave us several examples of supporting patients with protected characteristics under the Equality Act. Staff we spoke with displayed knowledge and understanding of the training on equality and gave examples of how they applied this learning.

The service had an in-date equality and diversity policy which we reviewed and found to be detailed. Further, the service completed equality impact assessments for each of their internal policies. Equality impact assessments are tools used to identify any negative impact a policy may have on a group of people with protected characteristics.

Surgical patients' individual needs were discussed during booking and pre-admission assessment. Staff used this information to provide safe care and treatment and mitigate any possible risk to the patient. If during pre-admission assessment staff identified the service could not meet the patient's needs, staff would not treat the patient at the hospital and refer the patient to an alternative health care provider who could support the patient. The hospital did not have the facilities to support the care of patients with high complex needs. Therefore, this patient group was not admitted to the hospital. However, patients who had a learning disability or dementia could be admitted subject to the outcome of risk assessments.

Patients received information explaining about their surgical procedures and what to expect throughout their hospital visits. This information was designed to address patients' questions about their forthcoming procedures. Information included details on preparing for hospital, what to bring with you and what to expect following their treatment. This information was also available to patients on the hospital's internet webpage.

Good

Surgery

The hospital had measures to meet the Accessible Information Standard (AIS). Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. At the daily hospital staff meeting patients who met the accessible information standard criteria were discussed to ensure their information and communication support needs were met and they received smooth patient care across the hospital. Information leaflets were also available in large print and could be obtained in braille if required. Hearing loops were available across the site.

Staff working on the surgical ward used coded discs on their patient board to identify patients who needed additional support. Staff told us this was a good visual reminder for them that they might need to use a different communication style when caring for the patient. For example, if a patient had a needle phobia or was hard of hearing. Staff showed us communication aids they used to help interact with their patients if needed.

The service had access to an interpreting service for patients whose first language was not English and signers if needed. We saw posters in different languages which explained services the hospital offered such as verbal translation and interpreter services and how to make a complaint. Staff we spoke with were aware of how to use these services and gave us examples of supporting patients who needed an interpreter. Further, staff were aware of the national guidance to not use family members, friends or staff members who could speak a foreign language, unless in an emergency.

Access and flow

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

The hospital followed corporate and local policies and procedures for the management of the patient's journey, from the time of booking the appointment until discharge and after care. Staff we spoke with were aware of these policies and procedures.

The hospital offered a flexible service that included variable appointment times and choices regarding when patients would like their treatment, subject to consultant and nurse availability.

The hospital had established a clear booking process for appointments and hospital admissions. Patients told us the hospital had a good and efficient booking process.

The surgery service could conduct their patient pre-assessment either over the telephone or face-to-face dependent on the type of surgery they were having.

The hospital offered both day-case or inpatient surgical procedures. Day-case surgery did not require an overnight hospital stay. Inpatient surgery required the patient to remain overnight or longer after the surgery was completed, for care or observation. Day-case patients were told to bring an overnight bag with them just in case they were required to stay overnight. For example, if the patient was nauseous after surgery or had no support at home. We were given examples by staff when this had happened.

The booking team added patients to the hospital's patient information management system. This meant staff working throughout the hospital could track patient details and appointments.

Patient feedback was positive, saying they had access to timely appointments, care and treatment which met their specific needs.

Good

Surgery

As per NHS guidelines, NHS patients attending the hospital had their referral to treatment time (RTT) recorded. The hospital also had an up-to-date referral policy, which we reviewed and found to be in line with national standards. In the past 12 months, the hospital reported an average RTT of 90% for NHS surgical patients. This meant the hospital did not always meet the target of 92% of NHS admitted patients beginning treatment within 18 weeks of referral. However, targets were reached between October 2020 and April 2021, with an average of 99%. Senior staff told us targets were not met during May 2021 to September 2021 due to the impact of COVID-19, which had restricted their capacity as they had been supporting the local NHS trust with chemotherapy and outpatient services.

The hospital cancelled 46 procedures in the past 12 months for non-clinical reasons. The service monitored cancellations to look for trends, themes and contributing factors. During this time period the highest factor in non-clinical cancellations was patients' choice not to have the operation.

Learning from complaints and concerns

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

The hospital followed the Spire Healthcare complaints policy which gave clear processes and timeframes for dealing with complaints. The hospital director had overall responsibility for the management of complaints. The average time to respond to complaints in the past 12 months at the hospital was 18 days which met the internal 20-day target.

All staff we spoke with were aware of the complaints procedure. Clinical staff told us they always tried to resolve any issues or complaints at the time they were raised. If this was not possible, patients could be referred to the nurse in charge in the first instance.

Patients could make complaints in various ways, verbally, by telephone and in writing by letter or email. We saw posters throughout the surgery service explaining how patients could make a complaint. The hospital's webpage had a detailed page explaining the complaint procedure and how to make a complaint or raise a concern.

The hospital received 56 complaints between January 2021 and December 2021 with 12 complaints relating to the surgery service. Complaints in the surgery service tended to be due to lack of communication. None of these complaints had been referred to the Parliamentary and Health Service Ombudsman (PHSO) or the Independent Healthcare Sector Complaints Adjudication Service (ISCAS).

We saw evidence that hospital complaints were discussed and addressed at the clinical governance meetings, in the medical advisory committee and departmental meetings. Any complaint themes or trends were analysed and actions put in place to stop them occurring again.

Staff said learning from complaints and concerns would be communicated to them mainly at handovers, team meetings, emails and notice boards. Complaints were also discussed at the daily communication meeting meaning heads of departments heard about complaints from elsewhere in the hospital. This promoted shared learning from incidents throughout the hospital.

Are Surgery well-led?

Good

Surgery

Good

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

Leadership

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

A new hospital director had been appointed. There was an interim director of clinical services (DCS), and a clinical governance manager. Senior leaders also included a Finance Director and an Operations Director. The medical advisory committee (MAC) chair and heads of department supported the senior management team.

The management structure had been reviewed and new positions recruited, including a new health and safety manager. The ward and theatres were led by ward and theatre managers.

The leaders had the skills and abilities to run the service and understood the priorities and issues the service faced. Staff told us they were very visible and approachable in the service for patients and staff. The hospital director and the director of clinical services completed a daily walkaround and the DCS spoke with some patients each morning.

Staff felt that the re-structure of the hospital allowed for better development of staff. Heads of department were empowered to address issues themselves before escalating.

The hospital director and MAC chair met each week. Discussions were documented and described as honest, robust and supportive.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff understood and knew how to apply them and monitor progress.

The provider's vision was: To be recognised as a world class healthcare business and its values as an organisation were:

- Driving clinical excellence
- Doing the right thing
- Caring is our passion
- Keeping it simple
- Delivering on our promises
- Succeeding and celebrating together.

The vision, mission and values were displayed on the ward and screen savers.

The clinical strategy was underpinned by the provider's purpose which was to 'make a positive difference to our patient's lives through outstanding personalised care'.

Good

Surgery

Progress against this strategy was being made through improvement work following the previous inspection. The hospital was scoring higher in the patient satisfaction surveys and work was ongoing to develop staff.

Culture

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

Staff we met with were welcoming, friendly and passionate. It was evident that staff cared about the services they provided and were committed to providing the best possible care to their patients. Staff told us that they felt supported by their departmental managers. The leadership team were proud of how staff had adapted to the changes throughout the pandemic. Staff felt they were kept up-to-date and although the changes had felt overwhelming, they understood they were important and felt that the service was safer with the patients being taken. Staff told us that the they worked together well and made shared decisions.

The service had two freedom to speak up guardians who were trusted and respected throughout the hospital. All staff we spoke with were able to identify the guardians and knew how to get in contact with them if they had concerns. We also saw posters displayed on the wards about the freedom to speak up guardians. Further, the freedom to speak up guardians received protected time to carry out their specific duties.

There was a complaints policy and system for patients to provide compliments and complaints. There were two main ways for patients to provide feedback, the first was a written feedback form that could be posted in a feedback box at reception. The second was an electronically submitted feedback form. The link to this was also detailed on the written feedback forms. All staff and patients we spoke with told us they would feel confident to raise concerns if they needed to.

The service had a hospital-wide Inspiring People Awards system where any member of staff can nominate someone for inspiring others and going the extra mile. Nominations are shared at the daily 10@10 meeting with awards presented by the hospital director. The daily 10 at 10 meetings included ‘daily shouts’ where the teams could share feedback about a member of staff who had been particularly supportive or received a compliment. There was also a ‘shout outs’ slot for special recognition to be shared.

The service had an up-to-date WRES (workforce race equality standards) report for 2021-2022, with detailed information and an action for 2020-2025. The service recognised the need for more efforts to recruit people with protected characteristics, particularly at executive level and had clear actions planned to achieve this.

Processes and procedures were in place to meet the duty of candour. Where errors had been made or where a patients’ experience fell short of what was expected, apologies were given, and action was taken to rectify concerns raised. When incidents had caused harm, the duty of candour was applied in accordance with the regulation. The hospital collected data from patients and used it to monitor performance and put in measures to improve patient care. In the past 12 months, the service had reported no hospital acquired infections, no hospital acquired pressure ulcers and one Pseudomonas bacteremia infection.

All staff said they felt that the senior leadership team and their managers were very approachable and felt they could raise any concerns.

Good

Surgery

Governance

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

There were governance structures, processes and systems of accountability to support the delivery of good quality services and safeguard high standards of care. The hospital's governance and assurance framework were supported on site and by Spire Healthcare, such as medicines management and infection control. Each committee had terms of reference which were reviewed annually. The committees met regularly and fed to the MAC, and corporate quality governance board.

We reviewed the minutes of the last three MAC meetings and saw they discussed incidents, complaints, audits, new appointments and practising privileges.

Clinical effectiveness meetings had been increased from quarterly to monthly. 'Rapid Response' meetings had been increased from monthly to weekly for managers to review incidents. Discussions were therefore current, and incidents were investigated more promptly.

The 10 at 10 daily call with all department heads was very detailed. Each department fed back their staffing situation including how many agency staff there were. There were updates including any returns to theatre, patient transfers, new incidents reported, safeguarding issues, IPC, complaints, consultant daily visit compliance and any issues from the resus huddle. It was checked that the RMO had enough rest overnight. Leaders on site were clarified and mental health first aiders identified. Any flash alerts were shared.

There was a clear policy about the introduction of new surgical techniques. Applications were reviewed with the local MAC and corporately to ensure the supporting evidence was sufficient to ensure the safety and effectiveness of the procedure. They had to set out the risk and benefits to patients of the procedure, as well as the cost.

Practicing privileges is a term used when doctors have been granted the right to practice at an independent hospital. The policy included the granting of practising privileges, and roles and responsibilities. The hospital director and medical advisory committee (MAC) had oversight of practising privileges arrangements for consultants. We saw evidence in MAC meeting minutes of discussion about renewing or granting of practising privileges. Most consultants also worked at other NHS trusts in the area. To maintain practising privileges, medical staff had to provide evidence of an annual whole practice appraisal, indemnity cover, an up to date disclosure and barring service (DBS) check and evidence of completed training. A biennial review was undertaken for each consultant's practice by the hospital director.

There were systems to ensure that data and notifications were submitted to external bodies as required. The hospital submitted data to the Private Healthcare Information Network (PHIN). They also collected Patient Reported Outcome Measures (PROMS) data for certain surgical procedures, such as hip and knee replacements. The service participated in national audits including the National Joint Registry.

There was a systematic programme of internal audit used to monitor compliance with policies such as hand hygiene, health and safety and patient pathways. Audits were completed monthly, quarterly or annually by each department depending on the audit schedule. Results were shared at relevant meetings such as governance meetings.

Monthly ward meetings were held, regular agenda items included learning from incidents, training and development, audit results, risk management, complaints and patient feedback.

The hospital director had weekly meetings with the chair of the medical advisory committee (MAC).

There was also a weekly governance message issued. Further, the service had a service level agreement with the local NHS trust to ensure rapid response, multi-disciplinary working and continuity of care. Feedback from the local trust regarding collaboration and support during the pandemic was very positive.

Management of risk, issues and performance

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

There were processes for identifying, recording and managing risks. Each department had a local risk register, alongside a hospital-wide risk register. Known risks and mitigation in the surgical service were discussed at senior team governance meetings such as the monthly clinical audit and effectiveness committee and the quarterly medical advisory committee.

The top risk was identified as the hospital 'not being able to recruit clinically trained and competent staff, requiring the regular use of agency staff'. There were plans to upskill HCAs (healthcare assistants) and for nursing staff to be multi-skilled, allowing for flexibility between departments as well as ongoing development for staff to encourage them to stay at the hospital.

The surgical service had a risk register which we reviewed and found that each risk had a rating, a named risk owner and a review date. Risks included recruitment, ability to meet all POA (pre-operative assessment) standards, having complete contemporaneous patient records and patients being fluid starved longer than two hours.

Improvements had been made to ensure the patients being accepted were suitable for surgery at Spire Dunedin. This included an initial review by the DCS to approve the referral met the local criteria before it went to the pre-operative assessment team. Processes to escalate concerns were more robust. The POA team could request MDT at any time and there were theatre planning meetings held the week before where there was another opportunity to request an MDT if they had concerns. These meetings were minuted and had the decision recorded in the patient record.

A quarterly Learning from Incidents newsletter was shared with all staff and a Quality Catch Up meeting held twice a week with all Heads of Departments and Senior Management Team to learn from incidents and celebrate successes and good practice. The service encouraged Excellence reporting which was promoted daily and recorded in the incident reporting system to celebrate when things go right. This could be excellent management of an incident or complaint, or where a colleague had gone the extra mile in their work.

Information Management

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

The service collected data and analysed it, in easily accessible formats, to understand performance. The information systems were integrated and secure. Data or notifications were submitted to external organisations. The provider had systems to ensure notifications of serious incidents causing harm to patients were reported in line with national requirements. The service used paper records. Nursing and medical patient records were combined within the same record. This meant all health care professionals could follow the patient pathway clearly.

Good

Surgery

Systems were in place to gather, analyse and share data and quality information with staff, key stakeholders and the public. The hospital had access to local information and other Spire Hospital information to benchmark services.

The service had a website where people could access information about the surgical procedures available and which would be useful when visiting the hospital. Staff had access to the intranet to gain information relating to policies, procedures, professional guidance and training.

A range of IT systems were used to monitor the quality of care. An electronic staffing safe care tool was used by the hospital to analyse staffing ratios against the acuity of patients.

Engagement

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

People's views and experiences were gathered and acted on to shape and improve the services and culture.

A patient forum led by the Head of Business Development was held quarterly. Complainants were often invited to this for feedback. The director of clinical services visited a few patients each morning and fed back any issues identified. Learning was shared at the quality huddles.

A staff survey was distributed, and forums held in areas that did not score well, without the managers present. Action plans were then developed with the managers to address the issues. We reviewed the action plans and found that they were detailed and addressed each item raised by staff with concrete steps to improve and mitigate risks. For example, we saw action implemented around staff concerns for security alarms if working late hours, and introduction of wellbeing as an agenda item for daily huddles.

The hospital continued to collaborate with the local NHS trust to ensure they were taking the correct patients and met quality key performance indicators.

We spoke to the housekeeping team, who had received an award following an inspection visit. Staff told us they were very proud to work for the hospital and felt very supported by senior management.

We also saw that various events had been organised to boost staff morale and improve engagement with all staff members. To capture exceptional actions of staff in each department as they occur, the service had introduced 'Going The Extra Mile for Team Dunedin' books. These had been in place since the start of the year with comments shared at the department daily briefings. These comments were also used to further inform the Inspiring People awards and Excellence reporting.

Learning, continuous improvement and innovation

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

Good

Surgery

A new virtual resus training programme was being introduced, whereby staff would complete simulation training every three months to maintain their skills via a simulation station that would provide real time one on one feedback. This was particularly important when most staff would not use their Basic Life Support (BLS) skills between annual training sessions.

Staff we spoke with felt supported by their leaders to develop and access new learning. Further, staff told us they were able to get time back for any learning or training courses completed outside of working hours and they had protected time for essential learning.

Good

Medical care (Including older people's care)

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

Are Medical care (Including older people's care) safe?

Good

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

Mandatory training

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

Nursing staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. Staff accessed mandatory training using an eLearning system; accessible via the internet. All staff including bank staff completed mandatory training modules and clinical competencies. For example, infection control, information governance, managing violence and aggression, safeguarding adults and children.

Staff compliance with mandatory training met local targets. The local target had been set at 95% and training figures showed targets for all mandatory training modules had been achieved. For example, staff training compliance for safeguarding adults and children and Mental Capacity Act 2005 was at 100%. Staff training in infection prevention control was 100% complaint. This meant that staff were compliant training required for the role.

Staff received mandatory sepsis training as part of the immediate life support training and within the Acute Illness Management course. Training compliance was at 100%.

Staff received mandatory training in basic and immediate life support. The course provided training in life support skills including defibrillation and basic airway adjuncts. These skills could be used to help save lives in the event of a cardiac arrest.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers provided data to confirm this and staff said the electronic system sent reminders to ensure training was up to date and reviews completed within set deadlines.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. The service did not treat children, however, all staff received training in safeguarding adults at level three and children at level two. Training figures demonstrated 100% compliance. This meant all staff had received mandatory training to help keep children and adults safe.

The hospital had a named safeguarding lead who had been trained to level 4 in safeguarding vulnerable adults and children.

Staff knew who the safeguarding lead was and how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. There were posters on display highlighting practices to be aware of, for example, female genital mutilation and domestic violence. Staff told us about their understanding of these practices and how they would escalate concerns. Staff had access to contact details for local authority teams and understood the benefits of working together to protect people.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Corporate and local safeguarding policies were available electronically and reflected current national guidance.

Cleanliness, infection control and hygiene

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

The areas for endoscopy and oncology patients were clean and had suitable furnishings which were clean and well-maintained. The clinical areas were compliant with Health Building Note (HBN) 00-03 Clinical and clinical support spaces. Staff were employed to ensure daily cleaning. All areas visited were visibly clean and had furnishings which could be easily cleaned.

The oncology department included six specific rooms to provide systemic anti-cancer therapy to patients with cancer. Patients received treatment as a day case and did not stay overnight. All furnishings were easy to clean. There was enough storage space for patients' possessions to discourage clutter. Floors had vinyl covering up to the walls and was compliant with HBN 00/10 Part A to make cleaning easier.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Records showed 100% compliance with infection prevention and control measures in the three months before the inspection.

Staff followed infection control principles including the use of personal protective equipment (PPE). All staff were bare below the elbows and had access to PPE which included masks, aprons and disposable gloves. Clinical hand washing sinks were available and had laminated prompts to remind staff of best practice hand washing techniques. We saw staff decontaminating their hands and equipment before and after patient care.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. A clear decontamination pathway for endoscopes was in place. Decontamination processes followed Health Technical Memorandum (HTM) 01-06: Decontamination of flexible endoscopes.

Records showed there was a robust tracking and tracing system which recorded each stage of the decontamination process for each endoscope, the persons involved, storage and subsequent patient use.

All equipment test reports were validated by an independent authorising engineer in decontamination.

Good

Medical care (Including older people's care)

Environment and equipment

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

The design of the environment followed national guidance. Patients attending for an endoscopy were cared for in the day surgery area, the endoscopy suite (within the operating theatre) and the recovery area. Access to these areas was restricted to approved personnel. Water was tested and reported to the water committee as required by the water safety management regime HTM 04-01.

Staff carried out daily safety checks of specialist equipment. Staff updated records which showed daily checks had been completed on the emergency equipment in day surgery and the oncology department.

The service had enough suitable equipment to help them to safely care for patients. The provider followed Health Building Notice 52 Volume 2 – Accommodation for day care Endoscopy Unit. All accessory items were marked as single use and used appropriately in accordance with Medicines and Healthcare Products Regulatory Agency guidance (2013). Staff had access to appropriate accessories for any immediate procedure related bleeds.

Staff disposed of clinical waste safely. Clinical and non-clinical waste was separated and stored safely until disposal. All sharps disposal bins were correctly assembled and disposed of safely.

The hospital had a policy to guide staff and raise awareness about what to do in the event of a cytotoxic spillage. They also stocked spillage kits for patients receiving systemic anti-cancer therapy (SACT).

Specimens for histology and cytology were transported to the histology department at a local NHS trust. They were transported in appropriate containers and packaging and labelled as diagnostic specimens. This ensured they were complying with the requirements of the Department for Transport guidance for packaging and transport requirements for patient samples.

The hospital had existing maintenance and repair contracts for all equipment used in endoscopy. There were lockable cupboards for the storage of hazardous cleaning chemicals, which met the Control of Substances Hazardous to Health regulations 2002 (COSHH).

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The hospital used the National Early Warning Score 2 (NEWS2) as their early warning system for identifying acutely ill patients. Audit results for compliance with the tool was 100% for October to December 2021.

Staff completed a pathway document for patients attending for an endoscopy procedure. This comprised of a detailed pre-operative assessment including; patient's medical and anaesthetic history, previous hospital admissions, any medication they were taking, and daily living arrangements.

Staff in endoscopy completed a five steps 'surgical safety checklist for endoscopy' for each patient. This is a recognised system of checks before, during and after surgery, designed to prevent avoidable harm and mistakes during surgical procedures.

Good

Medical care (Including older people's care)

Oncology nurses completed an assessment in advance of commencing systemic anti-cancer therapy (SACT). This included investigations such as blood tests, height and weight. This was part of a specifically designed care pathway, for oncology patients on admission. Patient's assessment included information about the risks of SACT, and how these risks could be managed as well as additional tests and follow up appointments and support.

Oncology nursing staff were trained to use the United Kingdom Oncology Nursing Society (UKONS) triage tool. Staff provided on call cover and used the triage tool with patients who had received SACT and who may be suffering from side effects of the treatment.

All patients receiving anti-cancer treatment were given an alert card at pre-assessment stage. This gave information to the patient and medical staff about the possible side effects of chemotherapy treatment including neutropenic sepsis. This was in line with National Institute of Clinical Effectiveness (2012) Neutropenic sepsis: prevention and management of neutropenic sepsis in cancer patients.

Staff contacted the patient's consultant if the triage tool indicated. Successful triage supported oncology staff to recognise emergencies and potential emergencies to ensure immediate assessment and required interventions were arranged.

Staff would contact the consultant if a patient needed immediate help during SACT treatment. Staff would also contact the resident medical officer (RMO) if the oncology consultant was not immediately available. The RMO was on site at the hospital 24 hours a day, seven days a week. The hospital had a transfer agreement with a nearby NHS trust and a policy for a patient who became acutely unwell.

Staff told us huddles were used to identify concerns or potential issues for the day. We attended a huddle where patient attendances for the day were reviewed and treatment plans discussed.

Staff shared key information to keep patients safe when handing over their care to others. For example, as the patient went from reception to the endoscopy area and recovery ward key medical information was shared with the staff.

Nurse staffing

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

The endoscopy and oncology services had enough nursing and support staff to keep patients safe. Managers used safe staffing tools to ensure staffing levels were reviewed. Staffing levels were displayed daily to demonstrate staffing levels met the required standard.

Managers and staff told us staffing was not an issue and staffing levels were safe. Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers accurately calculated and reviewed the number of staff needed for each shift in accordance with national guidance. The staffing tool was used to plan staffing for five days in advance. For example, the endoscopy staffing requirement was predictable as the department ran the endoscopy list on set times and days.

The service had low vacancy rates. The number of nurses and healthcare assistants matched the planned numbers. The service had low turnover rates. The leadership team and staff told us retention rates in the departments was good.

Good

Medical care (Including older people's care)

Medical staffing

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

The service had enough medical staff to keep patients safe. All care was consultant led. For example, consultants carried out all endoscopic procedures.

Consultants working at the hospital all had substantive posts in NHS trusts. Medical staff worked at the hospital under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital.

A resident medical officer (RMO), provided 24-hour, seven day a week cover at the hospital. There were two RMO's who provided cover. The RMO's usually worked one week on, one week off however during the pandemic this had extended to two weeks on and two weeks off.

An agency provided the RMO and the agency checked their competency. This included ensuring they had completed all the required training which included advanced life support.

Staff escalated immediate patient concerns to the RMO. Staff also reported timely access to consultants.

Records

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

Patient notes were comprehensive, and all staff could access them easily. We looked at 13 care records and saw all were contemporaneous and contained relevant information. Nursing staff entered electronic notes, consultants often provided hand-written notes. Nursing staff told us they could contact consultants directly if they had to query content.

Staff audited records on a regular basis. For example, electronic patient's record's and consent were audited monthly and demonstrated compliance in completion. We looked at records audits for quarter four and were 100% compliant. This meant there was a checking system in place to ensure compliance with good standards of record keeping.

Records were stored securely. Staff accessed electronic records with their own log in and passwords. Staff completed annual information governance training to ensure they understood the importance of safe storage. Staff stored hard copy records and documentation securely to protect the confidentiality of those who used the service.

Staff kept accurate endoscope tracking records in line with national guidance. This was to ensure all the items used during the procedure could be tracked in the event of a suspected disease transmission.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. The endoscopy area had medicines for sedation, pain relief and oxygen which is a medical gas.

Patients attending for endoscopy may have a procedure under sedation. The hospital had a sedation policy, and staff ensured medicines were available in case a patient had an adverse reaction to sedation.

Good

Medical care (Including older people's care)

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored securely and at the correct temperature.

Staff learned from safety alerts and incidents to improve practice. Medicines safety alerts were shared with staff promptly and used to improve practice.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Each patient received a cancer treatment record in the form of an informative booklet. The booklet was completed in collaboration with oncology staff. Patients were provided with mobile phone numbers that they could call in the event of an emergency and speak with an oncology nurse about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. An oncology pharmacist was employed on the ward. The pharmacist was responsible for ensuring safety in medication practices. Daily checks ensured safe medication storage and management in line with policy. The pharmacist audited processes regularly.

Staff followed current national practice to check patients had the correct medicines. The oncology pharmacist and pharmacy technicians were first and second checkers for dispensing chemotherapy. Staff carried out regular audits and provided reports to review errors and ensure learning. The electronic system allowed for a real time audit trail.

Controlled drugs were checked daily by trained staff and recorded in the relevant controlled drug registers. Pharmacists completed spot checks to ensure drugs were prescribed, stored and managed in line with their medicines policy.

Incidents

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

Staff reported incidents through an electronic system in accordance with the Spire Healthcare incident reporting policy. There was an internal process to report, record and seek advice as needed. Incidents were reviewed monthly, and actions were taken to mitigate any risks identified. Staff said they felt confident in raising and reporting concerns.

Staff said managers responded to all recorded reports and, where appropriate, followed up staff in gathering further information or signing off incident reports. Learning and feedback was shared with individual staff or wider teams depending on situation. Managers could access reports to look for quality of information, themes and shared learning.

The service had no incidents that met the criteria for a never event. Staff had access to wider learning from never events that happened in other departments or from the wider organisation. We saw examples of this in documentation and in discussions with staff.

Staff understood the duty of candour. Staff were open and transparent and gave patients and families a full explanation when things went wrong. There had been no reported incidents in oncology that required duty of candour. However, staff had experience of shared learning from other departments.

Good

Medical care (Including older people's care)

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. A governance lead oversaw the incident reporting system. Lessons learned and shared learning was a standard process across the hospital. Learning and improvement was shared with staff using a number of methods, for example during huddles, meetings, staff forums, and videos. We saw a learning board where incidents were written up with comments from patients and what the learning was.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff used wider learning from incidents to make local changes to keep people safe.

Staff met to discuss the feedback and look at improvements to patient care. Staff engaged in reviews of incidents using a number of methods. Staff reviewed all serious incidents and undertook full root cause analysis. Staff were supported by a national patient safety team who reviewed incidents and ensured relevant action was taken. Staff attended a clinical effectiveness meeting where morbidity and mortality was on the agenda for discussion.

Are Medical care (Including older people's care) effective?

Good

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. People's physical, mental health and social needs were assessed during pre-assessment. Staff delivered care, treatment and support in line with legislation, standards and evidence-based guidance. This included National Institute for Health and Care Excellence (NICE) and other expert professional bodies, to achieve effective outcomes.

Patients attending for endoscopic procedures were given information about fasting guidelines in line with the Royal College of Anaesthetists and NICE.

Staff in endoscopy completed an annual audit cycle as part of the operating theatre programme; this included the National safety standards for invasive procedures (NatSSIPs) audit. Results showed the service to be 100% compliant with these audits.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff received Mental Health Act training and we saw evidence of support for staff in assessing and managing mental health in the form of flowcharts with escalation and contact details. Staff told us they knew and understood the principles of the Code of Practice.

Staff completed an annual audit programme and analysed outcomes with actions associated to a nominated person within a timeframe. Staff said they aware of the location of audits. Staff discussed areas of non-compliance with designated senior managers, escalated for discussion to the appropriate meeting and an action plan agreed, developed and managed.

Significant non-compliance resulted in additional audits to monitor effectiveness of actions taken. In some instances, external audits were completed, for example, external audits for lasers. This meant there was a robust audit system in place to ensure ongoing safety and quality.

The hospital collected and submitted performance data to benchmark themselves against peer services. For example, they monitored clinical outcomes, patient satisfaction, cleanliness and incidents.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink. Patients were not allowed to eat and drink before endoscopic procedures, but staff offered them a light snack and drink after the procedure. During the post discharge telephone check the nurse checked they were tolerating food and drink.

Patients undergoing an endoscopy procedure that required bowel preparation or sedation were given appropriate fasting advice as part of the pre-assessment. Patients due to attend for a colonoscopy were given detailed advice on how to prepare for the procedure.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff ensured all cancer patients had completed baseline preassessments in line with national guidance. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. For example, a MUST nutritional assessment (MUST screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obesity). It also included management guidelines which could be used to develop a care plan. Audits were carried out quarterly to review compliance. Data we looked at recorded 100% compliance for completion of MUST scores.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

Staff monitored patients' pain during procedures and supported them to communicate their pain and discomfort. Patients attending for an endoscopy were offered an anaesthetic throat spray before their procedure to ensure comfort during the procedures.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff were committed to ensuring good pain management for patients on the ward. Staff gave us examples of where they had managed patients pain before commencing cancer treatments. This meant patients were able to better tolerate their treatment.

Patient outcomes

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

The service participated in relevant national clinical audits. Outcomes for patients were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve patients' outcomes. Staff routinely collected, recorded and monitored information about the outcomes of people's care and treatment (both physical and mental where appropriate).

Good

Medical care (Including older people's care)

Staff participated in a range of national scorecards and dashboards to monitor patient outcomes. We saw specific dashboards for cancer services that noted daily safety issues and measured incidents. This meant the team focussed on timely solutions to keep patients safe and improve outcomes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. There was an annual audit programme which was shared with staff. Staff followed provider care pathways which were developed for specialities, aligned to national best practice and latest guidelines. This meant that patients had an established pathway for all staff to follow to ensure consistency, reduce risks to patients and help empower patients by providing knowledge of what to expect. We looked at a range of cancer specialist audits which were completed on a quarterly basis. For example, we looked at cancer services quarterly Ardeo audit which was 100% compliant. This audit looked at information relating to patient's cancer treatment which was kept all in one place. Staff ensured all cancer patients had completed baseline pre-assessments, pharmacy care plan compliance, venous access assessment, which were used to develop patient specific care plans.

The service was accredited by relevant schemes. Staff participated in a number of accreditation programmes to stimulate continuous improvement. For example, MQEM - Macmillan Quality Environment Mark; a quality framework used for assessing whether cancer care environments met standards required by people living with cancer. Participation in these schemes demonstrated a commitment to quality care. It also provided evidence to benchmark over time against those who met required standards nationally.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers supported staff to complete further training relevant to their role and specific to the needs of the people they cared for. For example, staff received additional chemotherapy training. There were annual top up courses to ensure staff were up to date with their competencies.

Staff were provided with the skills and resources to assess and manage sepsis. Staff received mandatory sepsis training as part of the ILS training and within the Acute Illness Management course.

The Medical Advisory Committee (MAC) reviewed credentials of consultants before agreeing to them practising at the hospital. The MAC then monitored their right to continue to practice at the site on an on-going basis.

Staff working in endoscopy had training and were competent in clinical aspects of endoscopy which included for example, the support of patients through a procedure, management of specimens and the decontamination of endoscopes, endoscopic mucosal resection, management of gastro-intestinal bleed.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. A private room was available to communicate a serious finding during the endoscopy procedure.

Managers gave all new staff a full induction tailored to their role before they started work. Managers used a checklist to help ensure staff received all necessary information before taking up duties and to help them understand policies, procedures and their role and responsibilities. We looked at induction documentation and spoke with staff who told us they felt appropriately inducted before taking up duties.

Good

Medical care (Including older people's care)

Managers supported staff to develop through yearly, constructive appraisals of their work. All staff had a completed personal review, annual appraisal, supervision and had been provided with access to wellbeing interventions. Staff said they were given supervision to help them make sense of clinical and operational work carried out. This meant staff were supported in setting objectives, planning to meet those objectives and achieving results.

Multidisciplinary working

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

To ensure effective services were delivered to patients, different teams and health professionals worked together as a multi-disciplinary team. Consultants, registered nursing staff and healthcare assistants took part in a safety huddle before the start of lists.

Patients had their care pathways reviewed by the relevant clinical staff and consultants.

The MAC met quarterly and was attended by a range of medical consultants from most specialities. These meetings were an opportunity to discuss incidents raised, complaints about service, same day cancellations and all issues affecting service provision at the hospital.

There were effective multidisciplinary teams (MDT) in the endoscopy unit and oncology, in the hospital and externally with GP's. There was endoscopy representation at regular meetings with the theatre team. They attended the theatre huddle every morning.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Endoscopy and theatre staff held monthly meetings and these meetings were minuted. They included agenda items such as overall activity, theatre/endoscopy utilisation, clinical governance reports, staff appraisal and mandatory training.

Specialist nurses helped to prepare patients with cancer for surgical treatment. This helped to provide continuity of care and support. They also provided post-operative support and care.

Endoscopy and oncology teams discussed patient complaints and feedback related to their speciality and shared any learning to staff via email and a monthly newsletter.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. Patients could access extended clinics evenings and weekends to improve accessibility.

All patients attending the hospital for endoscopy procedures followed the elective pathway and admissions were booked in advance.

The oncology service was available Monday to Friday. Patients who were receiving systemic anti-cancer therapy could access out of hours support. There was 24-hour cover over seven days a week. The oncology team provided the cover for any patient that had concerns or any adverse effects.

Good

Medical care (Including older people's care)

Medical staff and members of the multi-disciplinary teams, for example physiotherapy were accessible 24 hours a day, seven days a week. Diagnostic services and laboratory services were available seven days. Pharmacy services were available Monday to Friday and on call over the weekend and public holidays with onsite attendance as required. A service level agreement was in place for pharmacy advice when the pharmacy on site was closed.

Health promotion

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

Staff assessed each patient's health at each attendance and provided support for any individual needs to live a healthier lifestyle. Patients were given advice on diet and fluids following treatment, to help ensure they maintained a healthy dietary intake.

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

Leaflets to support healthier lifestyle were available online or could be printed as requested.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. All staff were up to date with their Mental Capacity Act and Deprivation of Liberty Safeguards training as a mandatory requirement. Staff we spoke with knew and understood the principles of the Act.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff assessed individual needs of patients to ensure they understood what they were consenting to. For instance, an alert at booking and admissions prompted the need for translation services. Interpreters were used face to face for consent.

Staff clearly recorded consent in the patients' records. All records we looked at had consent clearly indicated and appropriately reviewed, signed and dated. Staff audited records for consent and demonstrated compliance by achieving 100% completion. Staff checked all relevant fields had been completed and that consent was recorded on each record. This meant there was a checking system in place to ensure compliance with good standards of record keeping.

Are Medical care (Including older people's care) caring?

Good

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

Compassionate care

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

Good

Medical care (Including older people's care)

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients said staff took the time to interact with people who used the service and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness. Staff responded in a compassionate, timely and appropriate way when people experienced physical pain, discomfort or emotional distress.

Staff followed policy to keep patient care and treatment confidential. Patients could access a private room for sensitive and confidential discussions. Staff only accessed and shared necessary information to the relevant people.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients. Staff showed an encouraging, sensitive and supportive attitude to people who use services and those close to them. Staff interactions with patients we saw demonstrated this. Administration staff took responsibility for admitting the patients, completing booking forms related paperwork. Staff greeted patients by their first names to help build rapport and reduce formality in what may have been a stressful experience.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff made sure that people's privacy and dignity needs were understood and always respected.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff interactions with patients were compassionate and understanding. Some staff were trained in mental health first aid and could provide emotional support to those who needed it.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We saw staff interact and communicate with patients with genuine care. Staff described a holistic model of care which enabled them to consider the whole patient and their family when caring for a patient undergoing treatment.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff provided patients with the time needed to discuss their individual needs and involved those close to them, including other agencies to help them understand what their care and treatment options were.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff involved families, carers and other professionals when there were for example neurological conditions that required additional communication support.

Are Medical care (Including older people's care) responsive?

Good

Medical care (Including older people's care)

Good

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

Service planning and delivery to meet the needs of the local people

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

Managers planned and organised services so they met the changing needs of the local population. Patients participated in a patient forum to contribute to the development of the service. The forum consisted of patients who had recently attended the hospital. Their contribution helped staff to understand their experiences and where they could make improvements.

Patients were provided with opportunities to feedback their views to help drive improvements and help make sure their treatment met the changing needs of people who used the service.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. Patients, where possible, were offered one stop appointments to avoid multiple visits to the hospital. Patients who required urgent appointments following consultations were seen at the same time wherever possible, for example to discuss bloods and scan results.

Patients had access to a consultant's online booking portal. This was a direct booking option for self-paying patients. Patients could choose their consultant and appointments to suit their needs including evenings and weekend appointments. This was in response to patient requests which meant they had the flexibility to choose appointments with consultants that suited their individual preferences.

Facilities and premises were appropriate for the services being delivered. The oncology ward achieved the Macmillan Quality Environment Mark. The Macmillan Quality Environment Mark was a quality framework used for assessing whether cancer care environments met standards required by people living with cancer. This meant that patients had access to an environment assessed as being suitable for their specific needs.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff made reasonable adjustments to help patients with additional needs. For example, help for patient's disabilities. People living with dementia were assessed in advance and involved relevant others, for example, families to ensure the appropriate support was put in place.

Managers monitored and took action to minimise missed appointments. Patients could access appointments to suit them where possible. Reminders could be sent and patients who did not attend appointments were contacted where appropriate. GP's or other involved professionals were copied in to missed appointment communication.

Meeting people's individual needs

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

Good

Medical care (Including older people's care)

Patients received written information ahead of their appointment which included specific instructions and information about what to expect as part of their care and treatment. For patients having an endoscopy procedure, the information included guidance on preparation, arrival time, the procedure and aftercare.

The day-case procedure pre-admission questionnaire included an assessment of people's individual needs, which included a question to check if any additional support was needed, to support effective communication and understanding.

Staff in the endoscopy service understood the needs of people living with dementia, and there were dementia champions on the wards to support staff and patients as needed.

Patients who attended for chemotherapy bypassed the main reception waiting room and presented directly to the department where they were allocated a room without having to wait. This was to alleviate anxiety in the patient group in having to wait to access their treatment and personal space within the hospital.

Patients with the need for translation services were supported by provision of interpreters. Staff could access additional communication aids for example, for those who with hearing impairments. The service had information leaflets available in languages spoken by the patients and local community. They were accessible in the hospital and were available in other languages or forms.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Language line was available and we were given examples of when it was used.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Patients could access a varied menu that changed periodically to increase choice and variation.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Staff worked collaboratively, for example, sharing information with partner agencies to provide joined up care which reduced duplication. Managers said they worked within NHS waiting time targets. There were no waiting times for admissions for private patients.

Following a GP referral for an endoscopy procedure, consultants assessed patients in the outpatient department. They reviewed patients to see if they met the admission criteria, carried out assessments and discussed a plan of treatment. Consultants carried out endoscopy procedures at a date and time to suit patients.

NHS consultants referred oncology patients following diagnosis at an NHS hospital. Patients were seen by their oncologist and then referred to the oncology team with a clinic appointment. Their consultant outlined the proposed treatment plan for the patient.

Oncology staff ensured the patient and consultant were kept informed if there were delays in the administration of treatment. They maintained a record in the patient's notes.

Good

Medical care (Including older people's care)

Patients were transferred out in the event of an emergency. Staff completed a transfer out form and presented the information to ambulance staff or nearest emergency department. A copy of the form was kept on the electronic record system.

Managers and staff worked to make sure that they started discharge planning as early as possible. All patients were provided with a patient discharge guide. The guide provided patient's with information about what to expect after treatment. This guide included a space to write questions and contact numbers for specialist staff should they wish to contact them following discharge. For example, they could contact the dementia lead nurse using the ward number. This meant that patients knew what to expect and could continue to contact professionals on discharge.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. Complaints information signage were displayed to support people in raising concerns. Information was also on the service website to help people raise complaints electronically.

Learning from complaints was shared widely and there was evidence of learning and changes made as a result. Learning was also shared Spire-wide so that lessons could be learned from other Spire locations. Patients were followed up after discharge, this was another opportunity to share feedback from their experience at the service.

Staff understood the policy on complaints and knew how to handle them. Staff had access to policies and information systems to help them learn from incidents and complaints.

Managers investigated complaints and identified themes. Managers responded to complaints informally in the first instance, then a more formal approach was taken for those could not be resolved locally.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service.

There had been no complaints directly relating to the endoscopy or oncology services during the period January to December 2021.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients and people who attended the ward with them were given feedback cards to provide information about their experience on the ward. We saw examples of when this feedback was used to make improvements. The feedback was also used to share with staff who had made a difference in a positive way to patient experience.

Patients gave positive feedback about the service.

Good

Medical care (Including older people's care)

Are Medical care (Including older people's care) well-led?

Good

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

Leadership

Leaders had the skills and abilities to run the service. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills.

The hospital had a clear management structure in place with defined lines of responsibility and accountability. However, there had been recent and significant changes in the weeks leading up to the inspection, with a new hospital director and interim director of clinical services in post.

Staff said the new senior management team were approachable and accessible. Staff were aware of the hospital values and strategy and we saw this displayed throughout the hospital.

The service leadership teams communicated effectively with staff across the service providing up to date and relevant information. The service leadership teams were involved in daily delivery of the service by attending daily meetings to help plan service activity and support staff in resolving issues of the day. Managers cascaded information and ensured staff were kept up to date with issues of day every day.

Information was shared in varying forms, for example, consultant newsletters, clinical dashboards and clinical scorecard dashboards. Staff held monthly forums and team meetings.

The service leadership teams supported staff progression and development. Staff gave examples where they had been supported in achieving higher qualifications and specialist training packages. Staff proudly told us of their advanced training, qualifications and apprenticeship scheme.

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

Vision and Strategy

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

The endoscopy and oncology services had mission statements and set of values that aligned with the hospital strategic direction.

The overarching statements for the hospital strategy were:

1. Clinical Quality / Excellence – “Make every patient count”
2. Health and Safety
3. Improving staff engagement and satisfaction
4. Delivering financials
5. Improving the consultant experience

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

Good

Medical care (Including older people's care)

Culture

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

Staff we met throughout the inspection were welcoming, helpful and friendly. Staff said they worked in a supportive environment and we saw cooperative and appreciative relationships amongst staff of all grades.

Staff told us they were able to speak up about concerns and were supported by managers to do this. The hospital had a freedom to speak up guardian to ensure staff could raise concerns in a safe and supportive way. A corporate level speak up guardian was available to the hospital guardian to provide support, and regular meetings were held with other role holders at other Spire hospitals.

Staff said there was a culture of celebrating success and we saw evidence which supported this. There appeared to be a genuine culture of support, value and gratitude.

Staff at every level were provided with the development they needed, including appraisal and career development conversations. Staff told us they were fully supported through appraisal to develop personally and professionally. Staff gave us examples of where they had been supported to achieve further qualifications and skills.

Governance

Leaders operated effective governance processes throughout the service. Staff at all levels were had regular opportunities to meet, discuss and learn from the performance of the service.

There was a well-developed and effective governance structure at the hospital. The governance, performance and quality meetings were structured around the clinical dashboard and discussions were focussed on this. All meetings within the governance framework were well attended and there were clear lines of accountability. The service leadership teams for endoscopy and oncology attended these meetings.

There were regular, monthly, staff meetings. They were recorded and discussed key topics, such as safeguarding, staffing, quality and risk, infection prevention and control (IPC), and learning from incidents. Minutes we reviewed confirmed these discussions took place.

Staff kept up to date with governance information including safety performance data by viewing related information on governance quality boards. Data was displayed in visual form which was easy to read and understand. We saw the boards were up to date and staff told us they were useful visual aids to view useful governance information.

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

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. There was alignment between the recorded risks and what staff raised as concerns. The risk register had clear lines of accountability and review dates to ensure risk was monitored and action taken to mitigate against the risks.

Good

Medical care (Including older people's care)

The hospital director told us incidents were dealt with in real time. All recorded incidents were sent to the hospital director and discussed at daily huddle by staff in each department. In addition, there was a hospital huddle, attended by all department leads, to discuss challenges and concerns for the day.

Any complaints received were discussed on a daily basis.

Staff had access to a raising concerns policy. Staff told us they knew and understood the process to raise concerns using the policy.

For our detailed findings on managing risks, issues and performance please see the surgery report

Information Management

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

The hospital had systems to capture and manage data to drive and improve quality performance. For example, the electronic reporting system meant the hospital could capture risks and monitor themes and trends. The system allowed the hospital to benchmark their outcomes against other comparable services both internally and externally.

Leaders proactively collected information and analysed it to drive improvements in care. Staff completed annual information governance and data protection training; they knew and understood how to keep patient information safe.

Information systems were easy to use and accessible to staff who were trained and provided with secure log in and passwords.

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

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services.

Staff proactively gathered patient feedback on their services. Feedback seen was positive and questionnaires returned by patients following their procedures reflected the comments seen on the hospital website.

Staff received a monthly newsletter which kept them informed of issues relating to topics such as pay reviews, health and well-being matters, vacancies and new starters and local events. Staff could engage in an annual company-wide employee survey.

For our detailed findings on engagement, please see the well led section in the surgery report

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

The new senior leadership team and service managers were responsive to feedback from patients and staff and worked to improve services. Noticeboards displayed comments from patients and staff, and actions the service had taken to improve services.

Good

Medical care (Including older people's care)

Services, in line with the hospital vision and values, aimed to recognise and resolve issues at source, share and act upon areas for improvement, and continuously innovate and adapt. Services empowered staff to feel like they could make a difference and their contributions were valued.

Good

Outpatients

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

Are Outpatients safe?

Good

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

Mandatory training

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

Staff received and kept up to date with their mandatory training. Mandatory training was comprehensive and met the needs of patients and staff. Training was a combination of computer based, face-to-face training and shadowing and contains 16 training modules. Staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

The training year ran from 1 April to 31 March and the end of year target was 95% compliance. In February, the department had met the target in five modules but had not yet met the target in the remaining 11 modules as some staff still needed to complete the training before the end of March.

For resuscitation training the department was 82% compliant. Hospital data and explanation showed the percentage for resuscitation training was impacted by staff on maternity leave. All staff were trained in basic life support for adults and children.

Managers monitored mandatory training and alerted staff when they needed to update their training. Regular reports were also created by the operations manager and shared with department managers to keep track of staff training records.

Medical staff received and kept up to date with their mandatory training. Mandatory training was largely provided by the consultant's host NHS acute trust. Managers monitored mandatory training and alerted staff when they needed to update their training. Locally managers kept details of training and prompted staff to complete training as per guidance and policies.

Safeguarding

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

Safeguarding children and vulnerable adults formed part of the mandatory training programme. All staff were trained to a minimum of level two safeguarding adults and children. Clinical staff were trained to level three and safeguarding leads to level four.

Staff we spoke with told us they had received safeguarding training to level three or four depending on the grade of staff. Staff were able to identify types of abuse and understood how and who to raise any concerns with. Staff knew who their safeguarding lead was and how to contact them. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had a safeguarding lead with level four adult and children safeguarding training. There were visible posters throughout the departing with the safeguarding leads picture and contact details. Staff could all name their safeguarding lead for adults and children. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Cleanliness, infection control and hygiene

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

Hospital audits for January, February and March 2022 showed hand hygiene was 100% compliant. The service also completed both assurance and procedural audits for use of PPE. Results for both across 2021 were above 95% for all quarters. PPE dispensing units were present throughout the department and most were complete with gloves and aprons.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Clinical areas were clean and had easy to clean furnishings which were clean and well-maintained. Items that had been cleaned had ‘I am clean’ stickers on them. The service generally performed well for cleanliness.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff wore masks appropriately and were bare below the elbows. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Clinical treatment beds were clean and had disposable paper coverings in use.

However, in one outpatient clinic room we saw a PPE dispensing unit that was empty of aprons.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use them. Staff did not always manage clinical waste well.

The design of the environment followed national guidance and had suitable facilities to meet the needs of patients' families. The outpatient’s department was across three different locations. The department was easily accessible with adequate car parking for visitors. The reception had staff available who directed visitors to the area of their appointment. A newly refurbished department in the main hospital site was clean, tidy and well maintained with hot and cold refreshments available for patients.

The service had enough suitable equipment to help them to care for patients. Resuscitation equipment was easily accessible. We checked the resuscitation trolley used for adults and children. The security seal correlated to the log and

there were no gaps in the daily checklist. The items inside were well organised, in sealed packaging and were in date. Items with nearing expiry dates were clearly marked and documented in a separate log. The oxygen cylinder was attached securely and indicated green showing level of oxygen. There was good clear guidance for the use of emergency items and appropriate paperwork attached to the trolley, all aligned to the Resuscitation Council UK.

However, we found multiple pieces of equipment across the different locations, such as observation trolleys, eye examination machines, an observation lamp, a hyphenator machine, an Electromyography machine and a treatment bed, that did not have visible electrical safety testing stickers and were either missing or had out of date service stickers, so staff could not be assured equipment was safe. We also found a fridge in the hospital kitchen which did not have a current electrical safety testing sticker on it. We asked for assistance to find it, but on the day, staff could not find the sticker and when the fridge was moved, we saw the out of date electrical safety testing sticker. We spoke to the head of estates who explained that they arranged for an electrical safety testing engineer to attend the hospital and that all heads of department are responsible for advising which equipment they have that requires testing.

Staff did not always dispose of clinical waste safely. Hospital audit data showed the outpatients department was 100% compliant with sharps management. However, sharps bins were not always appropriately used as we saw discarded packaging in one bin from single use surgical staplers and some syringes in the bin still had fluid in them.

Assessing and responding to patient risk

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

Patients attending the department were generally fit, attending for an outpatient's appointment or consultation. This meant that patients did not routinely have clinical observations performed. Patient details were checked on arrival to outpatients and any concerns were raised with medical staff before any procedures commencing.

Staff told us patients undergoing simple procedures within outpatients were assessed by the consultant, supported by the nurse and healthcare assistant which could include clinical observations, blood testing or swabbing, and if procedure was appropriate to commence then consent was gained and the patient prepared for treatment. All results were reviewed before treatments commencing.

Procedures followed a checklist in line with World Health Organisation (WHO) guidance before commencing. The WHO checklist gives staff a set of priority checks to improve effective teamwork and communication and patient safety for all surgical procedures.

Staff responded promptly to any sudden deterioration in a patient's health. Staff were all trained in basic life support and there was resuscitation equipment in the different outpatient locations. Staff would call the crash team to assist for patients who had any sudden deterioration and once stabilised would be transferred via 999 admission to an acute NHS hospital.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff completed a surgical safety checklist with a minimum of two staff, the registered practitioner and consultant or surgeon, before commencing any procedures. The checklist has three steps to complete and staff complete the checklist in the room the procedure takes place in whilst the patients' were present and before

patients' leave. The checklist followed the WHO guidance for safe patient care. Patients were given advice leaflets following their procedures with information on who to contact should they have concerns. There was a 24 hour helpline for patients to access with any issues or concerns following their procedures. An operations register was kept, documenting all procedures carried out. This was stored securely behind a locked door.

Staffing

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

Staff were allocated to clinics to ensure that patients and doctors had access to support as necessary. Managers would calculate and review the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. The planned staff on the day of our inspection for outpatients department 16 was three, the actual staffing was three but from late morning there was not a nurse on shift, so this reduced to two staff, but the provider told us a senior leader was available for support.

Hospital data for a three month period showed outpatient vacancy rates at 32%, sickness rates at 4% and staff turnover at 15%. The hospital told us they were actively recruiting for vacant positions and use bank or agency staff as an interim measure to ensure patient safety. All bank and agency staff have an induction.

At the time of our inspection there was not an outpatients manager in post and the clinical governance lead was supporting in the interim.

Medical staffing

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

There were enough medical staff to keep patients safe. There were regular clinics for some services such as eye clinics, which meant that the booking team were able to plan appointments well in advance. Other clinics were arranged according to availability of consultants' schedules.

Following acceptance into the service, consultants worked under practising privileges. Practising privileges is a well-established process within the independent hospital healthcare sector where a medical practitioner is granted permission to work in a private hospital or clinic in independent private practice, or within the provision of community services. The majority of doctors also worked at nearby NHS acute or specialist hospitals and completed training and revalidation through their host organisation. The service ensured compliance with these as part of annual reviews and discussed reviews in staff meetings.

Records

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

Patient records were paper and were stored securely behind key coded doors in the department until required for appointments. Each consultant had a specific folder for the patients they were seeing in clinics that day. Consultants' names were clearly marked on the folders to aid identification and filing. Administration staff collated and distributed the records to the correct outpatients site each morning and collected them at the end of each day.

Good

Outpatients

Hospital data showed that patient records had been left out in a clinic room and therefore not securely managed. This was raised as an incident and discussed with staff as a shared learning event via monthly team meetings. However, during our inspection, we saw all patient information was kept securely.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. These were complete and in line with national guidance. The majority of medicines used were local anaesthetics which were used for some clinical procedures. These were stored securely and checked in line with best practice when used. Staff were able to access standard operating procedures (SOP) via their intranet.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicines were stored in the treatment room which was secure at all times. The temperature of the treatment room was monitored, and data was recorded in line with national guidance.

Medicines prescribed to patients to take away could be collected from the hospital pharmacy during working hours. Any medicines used within the outpatient clinics were collected by registered nurses from the pharmacy.

Incidents

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

Staff knew what incidents to report and how to report them. The service used an electronic reporting tool which was accessible to all staff. Hospital data showed that incidents were reviewed and investigated in a timely manner. Incidents were discussed at team meetings and learning shared across the hospital.

Patient safety alerts were shared daily as they are received and then in a monthly safety update bulletin which also summarised policy updates and new NICE guidelines. Patient safety alerts are issued by NHS England (NHSE) and NHS Improvement (NHSI) when they arise. This meant all staff were kept up to date with safety issues in a timely manner.

Staff understood about duty of candour and were able to give examples of scenarios where duty of candour would be required. Between 1 February 2021 and 31 January 2022, the hospital carried out five statutory duty of candour reports.

Between 1 February 2021 and 31 January 2022 hospital data showed the outpatients department reported a total of 60 incidents, with six graded as near miss, 45 graded as no harm and nine graded as low harm. Incidents were reviewed at staff meetings and were regularly discussed at management meetings and disseminated to staff for shared learning.

The service had no never events reported between 1 February 2021 and 31 January 2022. A never event is a serious, largely preventable safety incident that should not occur if the available preventative measures are implemented.

Are Outpatients effective?

Good

Outpatients

Inspected but not rated

We did not previously rate effective. In accordance with our current methodology we do not rate effective for Outpatients.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed a number of policies and saw that these reflected best practice and were in date. Clear review dates were set and there was a robust process for ensuring policies were reviewed. In addition to policies, the service had a number of standard operating procedures (SoPs) which were all based on current guidelines and reviewed regularly. Policies and SoPs were accessible in paper copies or via the intranet.

Staff we spoke with knew about the Mental Capacity Act and had completed dedicated training. Staff were able to provide examples of supporting patients with mental health needs, and also gave us clear examples of discussing, obtaining and documenting consent.

However, one example given of a patient who staff thought may not have had capacity, did not adhere to the principles of the Mental Capacity Act 2005 when they asked a relative to consent to the patient's treatment.

Nutrition and hydration

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

Patients received information to advise them about timescales for when they could eat and drink in advance of any invasive procedures. There were hot and cold refreshments available for patients in waiting areas. Light snacks were available for day case patients and the menu included diverse options to cater for patients' food allergies, cultural and religious needs.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

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

Staff did not routinely administer pain relief in outpatients unless patients were undergoing a procedure when some pain relief medicines may be given.

No controlled medicines were in use. Controlled medicines are drugs that are subject to high levels of regulation.

Patient outcomes

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

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. We reviewed audit results for the period 3 March 2021 to 31 March 2022 which showed 100% compliance in the World Health Organisation (WHO) five steps to safer surgery checklist audit, and 100% compliance in the hand hygiene audit and bare below the elbows audit.

Managers shared and made sure staff understood information from the audits. We saw that audit results were discussed across all areas of the service and discussed at staff meetings, management meetings and daily briefings. Managers and staff used the results to improve patients' outcomes, care and treatment.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients and used competencies to confirm skills. Managers gave all staff a full induction tailored to their role before they started work. There was a comprehensive induction process which included orientation, policy and procedures familiarisation and equipment competency. Agency staff completed the same induction process to promote safety and consistency. Managers supported staff to develop through yearly, constructive appraisals of their work. The appraisal rate for the service was reported as 100%, however some staff reported they had completed their sections of the appraisals, but managers had not. The provider told us appraisals were not fully completed but were in progress and not due for completion until 31 March 2022.

Consultants were monitored through the medical advisory committee (MAC) and any concerns were flagged and addressed accordingly. The application, removal, withdrawal and reviews of practising privileges was also monitored by the medical advisory committee. Consultants were not permitted to complete any procedures which they had not been deemed competent to complete. Hospital data from February 2021 showed 100% compliance in practising privileges across five mandatory areas but in one area showed non compliance which the hospital stated was due to the impact of the COVID-19 pandemic affecting face to face training.

Managers made sure staff attended team meetings or had access to full meeting notes when they could not attend. We saw meetings were well attended by staff and minutes were sent electronically to all staff to enable access.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff reported they were given time and were supported to develop.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care. Nursing staff reported they had good access to senior medical staff and could discuss patient related concerns with them.

Patients could see all the health professionals involved in their care. There were boards introducing the team in the waiting areas.

Good

Outpatients

There was a service level agreement with the local NHS in place which involved multidisciplinary teamwork to ensure continuity of care for all patients, including emergency transfers to the local NHS trust in an emergency.

Seven-day services

Key services were not available seven days a week to support timely patient care.

The service operated variable hours depending on the clinics but was available from 8am to 8pm Monday to Fridays in the main building. Outpatients 13 department operated from 8am to 4pm Monday to Friday. On occasion, some patients had been seen on a weekend, but this was not a regular occurrence.

Staff worked flexible hours to provide cover for clinics and provide appointments to meet patient's needs and could call for support from doctors and other disciplines, including mental health services and diagnostic tests.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They generally followed national guidance to gain patients' consent.

Staff generally understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff generally understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 (MCA). The service does not have a specific MCA policy. The hospital stated relevant references to the MCA are made in the safeguarding policy and consent policy. We reviewed both policies and they were in line with guidance and legislation.

Staff generally gained consent from patients for their care and treatment in line with legislation, policy and guidance and recorded consent in the patients' records.

Are Outpatients caring?

Good

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

Compassionate care

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

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

Patients said staff treated them well and with kindness. One patient we spoke to said the level of care they received was 'fantastic and I couldn't ask for better'.

Staff followed policy to keep patient care and treatment confidential. Patient information was kept securely, with medical notes in treatment rooms with doctors and staff. All discussions were held in rooms which prevented unauthorised persons overhearing key personal information.

Good

Outpatients

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients we spoke with told us that staff were very supportive, and explained treatment plans, and procedures which helped to reduce their anxiety.

Chaperones were also offered for any patient attending appointments on their own who may require a physical examination. Chaperone signs were clearly displayed across outpatient waiting areas. Staff told us chaperones would be provided during consultation if requested.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment. Patients we spoke with felt well informed and involved in the decision making regarding their care and treatment. Patients said they were well informed of their treatments, were given post procedure advice and support.

Patients said they were aware of any costs associated with their treatment before commencing it. Staff told us they would involve relatives of patients when providing care and treatment and would rearrange appointments where necessary to ensure relatives could attend to support patients.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service. Hospital data from the 'Friends and Family survey' between January 2021 and January 2022, showed that on average 70% of people said the experience of the service was 'very good' and 58% were 'extremely likely' to make the hospital their first choice again.

Hospital data from the patient feedback survey showed that patient feedback was used to improve the outpatients department waiting areas through a complete refurbishment, as patients had described it as unwelcoming.

Are Outpatients responsive?

Good

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

Service delivery to meet the needs of local people

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

Services were planned and delivered to meet the needs of the local population. Patients could choose appointments which suited them. Patients were treated equally regardless of whether they were NHS patients or self-funded patients. Facilities and premises were appropriate for the services being delivered. Consultation rooms were large enough to enable patients and clinicians to attend. There was lift and ramp access to outpatients 22 for anyone requiring wheelchair access or difficulty with climbing stairs or walking distances.

The service had clear and visible information on how to raise concerns and procedures were followed to respond to any concerns raised. Hospital data for the past 12 months showed the average time to respond to any complaints was 18 days. The hospital target for response was 20 working days. The overall target was 80% and by the last quarter of 2021, the response result was 90%.

Patient information boards were present and included information on language needs and accessible information standards, how to make a complaint and patient feedback.

The hospital does not currently monitor cancellations so could not provide accurate cancellation information.

Meeting people's individual needs

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

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service had information boards in outpatients areas to advise patient there were translation and interpreter services available. The boards also had information for those who have a disability, sensory loss or impairment and require information in a suitable format for their individual needs. This was in line with the accessible information standards.

We saw from staff newsletters that awareness for those who identify as LGBTQ+ was raised through the LGBTQ+ history month.

Some outpatient areas were not designed to meet the needs of patients living with dementia. Although some outpatient areas were well lit, the general design and environment was not well suited to those living with dementia. The age of some of the buildings will have an impact on this, but there was some appropriate signage and a clock to aid being dementia friendly. It was not clear what percentage of the hospital's demographic may be living with dementia.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Hot and cold refreshments from a machine were available to patients attending appointments. Day case patients could choose from a varied menu of light snacks and drinks. Patient feedback from a survey prompted this menu to offer a more extensive range of foods, which the head of catering then implemented.

Access and flow

People could generally access the service when they needed it and received the right care. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

Hospital data provided stated that referral to treatment times had been impacted by the COVID-19 pandemic and was below the 18 week threshold. Their target of 92% had not always been achieved during 2021, with quarter one at 93.1%, quarter two at 90.3% and quarter three at 88%. However, the hospital does expect to return to being below the 18 week threshold target in 2022. Hospital data showed that 35,505 patients were seen in outpatients between February 2021 and January 2022.

Patients in the eye clinic were given contact details for advice and support to access for both in, and out of hours services.

Good

Outpatients

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns and the service clearly displayed information about how to raise a concern in patient areas. There were posters with information on how to provide feedback electronically and on the hospital website. Patients we spoke to felt confident in making a complaint if they wished to and staff knew how to acknowledge complaints. Complaints were discussed at team meetings and any learning shared with staff

Managers investigated complaints and identified themes. Data provided showed there were 56 complaints between January 2021 and December 2021, and these were categorised by departments and themes. The hospital has a complaints policy which followsIndependent Healthcare Sector Complaints Adjudication Service Code of Practice for Complaints Management guidance. Managers shared feedback from complaints with staff and learning was used to improve the service. Learning and action points were provided which showed improvements had been made in areas such as communication, patient needs and process improvements.

Are Outpatients well-led?

Good

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

Leadership

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

At the time of our inspection, the outpatients department did not have a manager in post. The clinical governance lead was overseeing the role**.** Staff we spoke to were aware of the interim management arrangement and knew to raise any issues, concerns or questions to them.

The hospital had a clear management structure in place with defined lines of responsibility and accountability. The hospital was led by a senior management team consisting of a hospital director, an interim director of clinical services, a finance director and an operations director. The senior team were knowledgeable about their service issues and continually made plans to improve the service.

Staff spoke positively of the service and senior leads and felt they were valued by leaders. We saw positive interactions between staff which demonstrated that there was regular contact between staff groups and levels. Staff said one leader would do a walkaround at the end of the day to see staff before they went home. At the time of our inspection there was not an outpatients manager in post. As an interim measure, the clinical governance manager was overseeing the outpatients department.

For wider hospital leadership please see main surgery report.

Good

Outpatients

Vision and Strategy

The service did not have a vision for what it wanted to achieve or a strategy to turn it into action.

The service followed the Spire Group strategy 2021 which had five key areas of focus which included, clinical quality and excellence, health and safety, improving staff engagement and satisfaction, improving the consultant experience and delivering financials. The key areas were shared with departments and teams, who would then develop their own departmental strategies, which then created a whole hospital strategy.

We did not see any additional vision or strategy evidence for this service but post inspection the service provided evidence of a strategy for outpatients, with five key themes.

For wider hospital vision and strategy please see main surgery report.

Culture

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

All staff we spoke to said leaders were visible, approachable, available and friendly. Staff felt confident to raise any concerns and issues with leaders and felt they were valued and listened to.

Leaders monitored survey results and encouraged staff to ensure their ethnic identity was recorded so that any areas for improvements could be made.

The service promoted equality and diversity and it was part of mandatory training. Managers and staff promoted inclusive and non-discriminatory practices. The provider had committed to meeting racial equality standards and had completed a WRES (Workforce Race Equality Standard) data and action plan for 2021/2022.

Leaders carried out twice weekly walk rounds seeking patient experience feedback. A patient feedback forum via electronic means had been created to support quality improvement in the hospital.

Patients and families were encouraged to participate in the 'Friends and Family test' and data for the last 12 months showed 82% of patients and families rated their experience as very good and 96% as good.

For wider hospital culture please see main surgery report.

Governance

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

Good

Outpatients

There was a clear governance and risk management structure with accountabilities for assurance being well defined. There was various sub - committees in place, such as health and safety and clinical effectiveness committee which linked with the clinical governance committee and the Medical Advisory Committee (MAC).

The service held monthly meetings which included risks, clinical governance, incidents, training, competencies and audits. The minutes gave clear updates on tasks and actions staff were required to do and who may be leading on those actions and a clear pathway of escalation to the senior leadership team

The MAC met quarterly and minutes showed discussions included key governance issues such as incidents, complaints and practising privileges.

The Clinical Governance committee and the Clinical Effective Committee held quarterly meetings. Minutes were shared with member of the committee for cascading with their teams and also fed back at departmental meetings.

Clinical risks were managed through clinical governance group and clinical effectiveness committee, audits and quality assurance activities. Risks were held on the site's risk register and were discussed at monthly governance meetings.

For wider hospital governance please see main surgery report.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact, however, there were no specific risks identified for the outpatients departments.

The hospital carried out a number of audits which monitored performance and compliance against standards. We saw that there were several outpatient specific audits which included, physiotherapy documentation, surgical safety checklist, environment checks and infection prevention and control.

The hospital had a comprehensive and well documented risk register with the named responsible staff member for any actions plans and outcomes to be carried out. The outpatients departments did not have any specific risks identified. Leaders explained that this was because no outpatient risks scored high enough to be put on the provider risk register.

Minutes from team meetings did not specify any identified risks but advised staff that risks were documented on a staff board and to familiarise themselves with risks on there. Patient safety alerts were shared daily as they are received and then in a monthly safety update bulletin which also summarised policy updates and new NICE guidelines. Patient safety alerts are issued by NHS England (NHSE) and NHS Improvement (NHSI) when they arise.

For wider hospital management of risk, issues and performance please see main surgery report.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvement.

Audits were completed by the service and data produced to inform of performance and areas for improvement. This included patient feedback to provide improvements for patient experiences.

Good

Outpatients

Staff completed general data protection regulation (GDPR) and information governance training and were familiar with how to maintain information security. Any issues with information management was discussed at team meetings and any learning shared.

Staff knew how to escalate information internally and externally and felt that systems were in place to facilitate that.

For wider hospital information management please see main surgery report.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

Patients were invited to respond to satisfaction surveys. Data between January 2021 and January 2022 showed that on average 71%. of outpatient experience was very good. The service also used regular emails and a staff newsletter to keep staff informed. Staff surveys were conducted and themes, issues and any actions were implemented following the survey, such as staff recognition announcements, the forming of a staff engagement committee and individual development training availability. The service had responded to patient feedback regarding the appearance of outpatients 16 and 22 and patient parking and the hospital has refurbished 16 and redecorated 22. Building 13 is awaiting a refurbishment in 2022. For patient parking, the hospital requested staff to park off site.

For wider hospital engagement please see main surgery report.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. There was a focus on continuous learning and improvement. The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements. Individual training improvements were available to staff who requested it.

For wider hospital learning, continuous improvement and innovation please see main surgery report.

Good

Diagnostic imaging

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

Are Diagnostic imaging safe?

Good

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

Mandatory training

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

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training was provided by a combination of computer based, face-to-face training and shadowing. There were 18 modules in the mandatory training and the compliance target per module was 95%.

Managers monitored mandatory training and alerted staff when they needed to update their training. Regular reports were also created by the operations manager and shared with department managers to keep track of staff training records. The hospital's training year ran from April to March with an end of year target of 95%. During the inspection, we saw the current staff training compliance on the hospital's system was 77%. Information provided post inspection showed compliance with mandatory modules ranged from 75% to 100%. However, the training year end had not yet been reached. Resuscitation training for the imaging department was 63% compliant and hospital data provided stated this figure was being impacted on by staff maternity leave.

Staff were able to complete training online, outside of their working hours and were remunerated for this.

Some staff in the diagnostics and imaging unit were cross sectional trained. This means they were trained in different imaging types such as Magnetic Resonance Imaging (MRI), Computerised Tomography (CT) and X rays. All MRI staff were trained in the use of cannulas, meaning they were able to insert tubing and syringes to administer contrast media.

Inductions for new staff were flexible in length and all bank or agency staff have equipment competencies included in their inductions.

Safeguarding

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

Good

Diagnostic imaging

Staff received training specific for their role on how to recognise and report abuse. Safeguarding children and vulnerable adults formed part of the mandatory training programme. Staff we spoke with told us they had received safeguarding training to level three. Staff were aware of the adults and children's safeguarding leads for the hospital and knew how to make a safeguarding referral if they had concerns.

The service had a safeguarding lead with level four adult and children safeguarding training. There were visible posters throughout the department with the safeguarding leads picture and contact details and staff knew how to contact them if they needed to.

Staff followed safe procedures for children visiting the service /department. Children visiting the department would always have a chaperone with them. This was usually a parent but could be the children's safeguarding nurse. All chaperones would complete the same safety questionnaires as patients having imaging or scans. Safety was promoted through recruitment procedures and employment checks. Staff had Disclosure and Barring Service (DBS) checks undertaken at the level appropriate to their role. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff generally used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. Equipment had visible 'I am clean' stickers dated the day of our inspection. The service performed generally well for infection prevention and control. Audits for handwashing showed the department was 100% compliant and for bare below the elbows was 95% compliant and there had been no hospital acquired infections reported in the last 12 months.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). We saw one member of staff in the department with a mask worn inappropriately, not covering their nose. All staff we saw were bare below the elbows. Dispensing units for PPE were present and full. However, we did see one PPE dispensing unit missing medium sized gloves, but complete with aprons and other sized gloves.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Green cleaning stickers were seen on numerous items throughout the diagnostics and imaging department dated the day of our inspection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. On the approach to the Magnetic Resonance Imaging suite (MRI), there were no obvious warning signs to alert people to the possible dangers but once inside there were clear signs. The door was a keycode entry which is in line with the Medicines and Healthcare products Regulatory Agency (MHRA) guidance for controlled access to MRI areas. Patients needing to enter the MRI suite used a bell to alert staff to their presence. Inside the MRI suite, there were clear warning signs alerting people to the magnet strength and patient information boards showing items that must be removed as they posed a risk of harm to people. There were posters in the imaging department providing radiation exposure information for patients.

Patient areas were clean and had suitable furnishings which were clean and well-maintained. There were two patient changing areas in the MRI department and two in the CT, X ray and mammography department. All were clean with

good safety information easily visible and secure lockers for patient belongings. Changing areas had lockable doors to provide privacy and dignity to patients using them. The design and layout of the MRI suite was suitable for patients with a disability. There was a large preparation area where patients were prepared for their scans. The room was clean, tidy and hand sanitisers on the wall.

The scanning room had sufficient space for staff to move around and for scans to be carried out safely. During scanning, all patients had access to a panic alarm button, ear plugs and ear defenders. Patients could have their choice of music played whilst being scanned and the room had mood lighting to aid relaxation for patients. There was a microphone which allows constant contact between the radiographer and the patient. Patients could see the radiography staff through a mirror in the scanner.

All relevant equipment in the MRI unit was labelled as 'MRI safe' or 'not safe' in accordance with The Medicines and Healthcare products Regulatory Agency (MHRA) recommendations, to indicate that these pieces of equipment were safe or unsafe to use in an MRI environment. In the event of an emergency, the scanner trolley undocks from the scanner and there was an MRI safe wheelchair to transfer patients from the scanner.

Patients could reach call bells and staff responded quickly when called. Patients in the MRI scanner were given call bells to alert staff to their needs and staff have constant visual contact with patients via monitors whilst they were being scanned.

The design of the environment followed national guidance. The service had suitable facilities to meet the needs of patients. The imaging department was on the ground floor and easily accessible from the main reception area. There were separate waiting areas for the MRI department and CT, X ray and Mammography area. The waiting areas were clean and hand sanitisers for adults and children were present. Drinking water facilities were also present. Patients requiring the CT, X ray and Mammography departments were escorted from the hospital main reception area to the department. Following their scans, patients made their own way towards the exits. We noted that signage for exits was not easily visible and some patients were unsure which way to go. There were clear signs for fire exits throughout the department.

The service had enough suitable equipment to help them to safely care for patients. Staff carried out daily safety checks of specialist equipment. Imaging equipment checking schedules showed that equipment was quality checked at appropriate intervals and were within their working tolerances. Yearly reviews for equipment from medical physics were in place. There was a quality assurance log that showed completed machine tolerance checks for the past three months.

However, we found two pieces of equipment, a mobile ultrasound machine and portable x ray machine that did not have visible electrical safety testing stickers on them, so staff could not be assured these items were safe to use. The mobile ultrasound machine had an out of date service sticker on it, dated May 2021 and the mobile X ray machine did not have a visible service sticker on it. Post inspection the provider gave evidence to show an up to date service on the x ray machine. The mammography scanner did not have a visible service sticker on it. Therefore, staff could not be assured this equipment was safe. This was brought to the attention of staff who verified the machines were in use, but they were unsure why the machines did not have safety testing and service stickers present.

Staff disposed of clinical waste safely. We saw sharps bins were used appropriately and were not overfilled.

Assessing and responding to patient risk

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

Good

Diagnostic imaging

Staff completed risk assessments for each patient on arrival, using a recognised tool. For example, the service used a magnetic resonance imaging (MRI) patient safety questionnaire. Safety questionnaires were given to patients or completed over the telephone at referral stage. The patient booking team also go through the questionnaire with patients and any issues were then highlighted to radiographers. Radiographers then check the completed safety questionnaires before commencing any scans.

We saw staff checking three-points of demographic checks to correctly identify the patient. We saw the Society of Radiographers "PAUSED" (Patient, Anatomy, User checks, Systems and settings, Exposure, Draw to a close) posters in the department reminding staff of good practice before scans. Completing the 'pause and check' provides assurance that the radiographer used the correct imaging modality, the correct patient and correct part of the body was scanned. Using the 'pause and check' also decreases the number of wrong site scans. However, the patient on this occasion reminded the operative they were having their left side and not right side imaged.

The department provided imaging for children as well and staff told us they will explain the processes and procedures and parents then sign and date the necessary forms. Staff said parents were used as chaperones for imaging and they also undergo safety questionnaires.

There was a process in place to identify any issues such as metal fragments in patients who required an MRI scan. Patients would have an X ray and staff would await the x ray report before commencing with an MRI scan.

In the event of an emergency, there were procedures in place for removal of a collapsed patient from the MRI scanner. Staff told us the procedure for an emergency and were confident in their explanation of what they would do in the event of having to remove a patient from the scanner in an emergency. The nearest crash trolley was outside the unit in the main corridor.

The service has a pathway for any patients who have incidental findings from their scans.

All staff completed adult basic life support (BLS) training. There was an anaphylaxis emergency kit in the MRI suite.

The department had annual quality assurance checks from medical physics from an NHS trust and there was a quality assurance spreadsheet to monitor the performance of imaging machines. CT machines and plain film X rays were quality assurance checked monthly by the radiographers. The mammography scanner was quality assurance checked twice daily when the machine was turned on and off and there was a spreadsheet detailing the timescales for imaging department machines to undergo quality assurance checks. There was a spreadsheet for the quality assurance of machine tolerances and these processes were in line with the Ionising Radiation (Medical Exposure) Regulations (IR (ME)R 2017). The (IR(ME)R 2017 is legislation intended to protect the patient from the hazards associated with medical exposures to ionising radiation.

There was guidance on the protection of pregnant patients during diagnostic exposure and local rules (local diagnostic reference levels (LDRL)) for radiation exposure were displayed. Diagnostic reference levels (DRL) are radiation dose levels for typical diagnostic examinations on standard sized adults and children for broadly defined types of equipment. LDRL are set with regard to national and European DRL and based on advice from a medical physics expert.

Good

Diagnostic imaging

An annual radiation safety audit summary was seen which showed the department had good standards of most X ray machines and rooms were well maintained. The summary stated the department had a 95% compliance with Ionising Radiation Regulations 2017 (IRR17) and 98% compliance with IR(ME)R 2017 regulations and provided a list of actions required to improve performance. We did not see an action plan to show how these improvements would be made, but leaders told us they were wanting to update their IR(ME)R policy.

An equipment competency list was used for all staff, whether contracted, bank or agency.

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

Patient radiation dose survey results were present in the mammography room, however they were from 2018. Patient diagnostic reference levels were displayed in the department. These are a benchmark in patient radiation doses and are considered a first step in optimising the imaging process. Patient doses were recorded as a total of all projections, including repeat imaging and then recorded onto patient notes so that all clinical history was visible for other clinicians. This is in line with the IR(ME)R 2017.

All rooms had clear signs for safe numbers allowed in each room.

Staffing

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

The department had four full time cross sectional trained radiographers and one regular agency staff also cross sectional trained. They have two full time general radiographers and one bank staff general radiographer. There was one vacancy in the department. Staff said recruitment processes had been slow but improvements have now been made. Staff said current staffing levels can cause issues if chaperones were needed. There was a rota for on call staff and staff told us this can be difficult to cover with current staffing levels and makes taking annual leave difficult. The number of staff able to be on call from March will reduce and this may effect on call services in the department.

The hospital worked as part of a hub with two other Spire hospitals and can adjust staffing levels when needed. Managers monitored staffing levels to ensure safe working levels were maintained.

There was an imagining manager in post and a deputy imagining manager in training. The manager could adjust staffing levels daily according to the needs of patients and calculated and reviewed the number and grade of staff needed for each shift. The hospital was part of a hub model, so staff can be brought in from two other sites if needed. Managers limited their use of bank and agency staff and requested staff familiar with the service if they did use them. All bank and agency staff had a full induction and understood the service.

Medical staffing

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

Good

Diagnostic imaging

The hospital had a service level agreement with a local NHS trust to provide them with reporting on imaging scans. Reporting radiologist were contracted under the practising privilege model with one specialist radiologist attending the hospital weekly to report on scans. The provider told us that, if a specialist scan was performed that the attending radiologists are not able to report, other specialist radiologists were available to support. Scans were sent to the NHS pool of radiologist for reporting on and turnaround times were approximately 48 hours. There was a rota system for the radiologist and the hospital can easily contact them for any queries or issues. The service can arrange for urgent scans to be reported on sooner.

In the event of any medical issues, the department would call the resident medical officer to attend.

Records

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

Patient notes were stored securely, comprehensive and all staff could access them easily. However, staff told us that sometimes the quality of information in the referrals they received was not always clear or well completed and they would have to clarify the information on them.

The service used radiology information system (RIS), and a communication system to load the images for the scans. Both these systems were password protected.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. The only medication used was contrast media. These are used to enhance visual quality of anatomy during imaging. Evidence of patient safety questionnaires for contrast medias that included any known medical conditions or allergies were used. A dispensing checklist for the use of contrast medias such as with prompts for staff to dispense in line with patient group directives (PGD) and to discuss dietary advice with patients was used. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.

Staff stored and managed all medicines and prescribing documents safely. Short dated drugs were monitored, identified and dates of expiration were documented appropriately. Room temperatures were monitored and documented appropriately. However, we did see a gap of two days in February where no room temperature checks were completed in the MRI department.

Medicines that required warmer temperatures before administration were stored appropriately.

Incidents

The service generally managed patient safety incidents well. Staff recognised incidents and near misses but did not always report them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff told us of a recent incident that occurred in the MRI department where a patient safety check was not completed well. The patient had been prepared for a scan and was in the MRI scanning room. Before the scan commenced, the

patient stated they had a pacemaker. Staff took appropriate actions to safely remove the patient from the MRI scanner and provided support and advice to the patient. Staff arranged for the patient to have their pacemaker checked by an appropriate cardiac doctor. The incident was not reported by the staff members involved and the reporting was delayed by approximately 48 hours. We saw this incident was shared with staff and that learning from the incident and changes to processes and checks were in the process of being completed or have already been completed. Staff involved in the incident were given further training and received support from the service and one member of staff was no longer at the hospital.

Staff received feedback from investigation of incidents, both internal and external to the service through meetings and daily briefings. Managers debriefed and supported staff after any serious incident through a process they refer to as a 48 flash report.

Staff meet to discuss feedback and look at improvements to patient care. The hospital had daily morning briefings to discuss any issues or concerns in relation to patient care, such as staffing levels, quality issues and incidents. These were also discussed at monthly team meetings.

Between 1 February 2021 and 31 January 2022, the department reported seven incidents of no harm, one of low harm and one near miss. The service had no never events in the last 12 months.

Are Diagnostic imaging effective?

Inspected but not rated

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed policies, procedures and guidelines information, which referenced guidance from professional organisations such as the National Institute for Health and Care Excellence (NICE), Control of Substances Hazardous to Health (COSHH), the Medicines and Healthcare products Regulatory Agency (MHRA) and the Ionising Radiation (Medical Exposure) Regulations IR(ME)R 2017.

Local audits were completed monthly, quarterly and annually to assess clinical practice in accordance with local and national guidance. Areas included in audits were infection and prevention control, patient experience, waiting times, image quality assurance, documentation, procedures such as ‘Pause and check’ and radiation badge audit for staff.

The service had local rules based on national guidelines. We found the local rules provided clear guidance on areas relating to hazards and safety and the responsibilities of staff to ensure work was carried out in accordance with the local rules.

Good

Diagnostic imaging

Nutrition and hydration

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

Patient outcomes

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

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

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

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. The induction did not have a specific timescale in which to complete and staff told us it depended how long individuals take but it was not clear if there was a specific deadline for inductions. Staff felt the induction was thorough and met their needs. Data provided by the hospital showed the induction covered hospital orientation, policies and procedures, documentation, IT systems and mandatory training.

Managers supported staff to develop through yearly, constructive appraisals of their work. The imaging manager does annual staff appraisal for the department. There were 11 staff in the department and the appraisal rates was 73%, the appraisal year ends on 31 March 2022. Therefore, there were three staff who have yet to have their annual appraisal completed.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Team meeting minutes were distributed electronically to all staff following any meetings. The department had daily huddle meetings and staff working that day were expected to attend. The hospital then had an MDT daily huddle meeting called 'ten at ten' where a representative from each department was expected to attend and escalate any concerns and share key messages.

Good

Diagnostic imaging

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had mentors as part of their development and they assisted with training needs and courses. Following an incident in the department, training was identified and staff were supported to complete the training.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff said they were confident to approach their manager for any training needs and managers made sure staff received any specialist training for their role. One staff member we spoke to had their training in imaging sponsored by the Spire Group.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The hospital had daily meetings with all staff levels, to discuss a range of topics including, staffing numbers for the day, safety alerts, meetings held that day, COVID-19 updates, catering and portering issues, bookings and cancellations.

The hospital used a local NHS trusts to provide radiology reporting services and have an agreed pathway for any urgent, critical and unexpected finding in diagnostic imaging. In addition, the hospital clinical nurse specialist attends multidisciplinary team meetings (MDT) onsite at the local NHS trust.

Radiology managers across the Spire Group have fortnightly meetings via electronic means to discuss any issues, concerns and share best practice.

Seven-day services

The service currently operates Monday to Friday and occasionally at weekends if there was a need for this but leaders advised current staffing levels would not accommodate this safely.

Key services were available to support timely patient care.

Staff could call for support from doctors and other disciplines for queries or issues with diagnostic tests. Staff told us they can call on specialist radiologists to assist with any queries or issues with scans. If they needed medical assistance they would call the resident medical officer (RMO). If patients needed urgent care, they would be transferred to a local NHS acute trust. Hospital data showed there were 24 reporting radiologists with most having generalist in scope but others covering specialities including, breast, musculoskeletal and cardiology.

The radiology department saw a very low number of paediatric patients but a paediatric nurse was available if required.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas. The hospital used laminated health promoting posters relating to COVID-19 in public areas. These reminded patients of the importance of social distancing and washing hands to reduce the risk of transmission of the virus. Information leaflets were provided for patients on what the scan would entail and what was expected of them before a scan. The service also provided information to patients on self-care following a scan.

Good

Diagnostic imaging

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care and gained consent from patients for their care and treatment in line with legislation and guidance. All staff we spoke with understood the requirements of the Mental Capacity Act 2005.

Managers did not monitor how well the service followed the Mental Capacity Act or make changes to practice when necessary. Data provided by the hospital showed that audits for consent were carried out for the imaging department and achieved 100% compliance.

Are Diagnostic imaging caring?

Good

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff were discreet and responsive when caring for patients and ensured their dignity was preserved during scans by providing gowns. Staff treated patients with dignity, courtesy and respect. Staff introduced themselves before the start of a patient's imaging scan, interacted well with patients when discussing the process of scans and took account of their individual needs.

Staff ensured that patients' privacy and dignity was maintained during their time in the diagnostic centre and during scanning. Patients had designated changing rooms and were provided with a gown if required in the changing room. Staff ensured patients were covered as much as possible during procedures to preserve their modesty and dignity.

We spoke to a patient who said staff had been welcoming, polite and helpful. They stated that the process of being referred to the hospital was mostly smooth but they experienced some delay in communication from the hospital regarding their appointment date.

Emotional support

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

Staff gave patients emotional support when they needed it. We saw staff showing consideration to a patients anxiety around being in the scanner and were verbally supportive and kept them informed of the scanning progress. We saw staff making patients as comfortable as possible. They ensured the patient was in control throughout the scan and gave them an emergency call buzzer to allow them to communicate with staff if they needed to. The MRI scanner had built in microphones to enable a two-way conversation and a mirror so that patients can see staff.

Good

Diagnostic imaging

Understanding and involvement of patients and those close to them

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

The service allowed for a parent, family member or carer to remain with the patient during their scan if necessary. There was a paediatric nurse who can also assist with younger patients needs if required. Patients and their families could give feedback on the service and their treatment and posters throughout the department showed information on how to do this via an electronic app and email. One patient said they were fully informed as to the procedure they were having that day and had been fully aware of any costs involved.

Patients gave positive feedback about the service. Patients were able to provide feedback via the hospital website, email and an app as well. Information about how to provide feedback or complain, was visible throughout the department. Survey results from the 'Friends and Family Test' January 2021 to January 2022 ranged from 46% to 85% of patients and families rated their experience as 'very good'.

Are Diagnostic imaging responsive?

Good

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

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the changing needs of the local population. However, the service currently ran Monday to Friday, so that may not fully accommodate those of working age easily.

Facilities and premises were appropriate for the services being delivered. Accessibility adaptations had been made to improve access for those with mobility issues. Information on language and translation services were available, and information in accessible formats were available too.

Staff told us patients were given information leaflets before any scans commenced.

Meeting people's individual needs

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

A range of diagnostic and imaging related leaflets were available to patients. Patients could also access information on MRI scanning and the different types of diagnostic imaging modalities from the Spire hospital website. Information leaflets and videos were available for younger people needing imaging or scans. The service had information available regarding languages and interpretation services available to meet the needs of patients and local community.

Good

Diagnostic imaging

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Information posters were throughout the department informing patients who needed information in accessible formats and staff made sure patients, loved ones and carers could get help from interpreters or signers when needed.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times for treatment were not always in line with national standards.

One patient we spoke to said it had taken quite some time to get their first appointment, but they were not clear what the delay was.

NHS patients for cardiology related scans were seen on Wednesdays and Fridays. This may hinder those who are working age and cannot be seen at other times. However, the provider has clarified that evening appointments are available.

Learning from complaints and concerns

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

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

Hospital data showed the service had six complaints in in 2021 and the hospital had 56 complaints overall. Complaints were investigated, analysed and categorised into themes and trends were identified by leaders and actions implemented to address the issues raised. Data showed the average time to respond to complaints was 18 days, which was in line with the hospital target of 20 days.

Evidence of the changes implemented as a result of complaints included changes to processes requesting scans and imaging, improved communication with patients when requiring further tests or samples and offering patients alternative areas to reception to complete necessary paperwork.

Are Diagnostic imaging well-led?

Good

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

Leadership

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

Leaders collaborated with partner organisations to help improve services for patients. They had a good working relationship with the local acute NHS trust and a specific contract with a trust for the reporting of imaging scans. The

department manager had good oversight of their team and the day to day operations of the department. Staff spoke positively of their manager, stating they were open, approachable, visible, knowledgeable and they had great trust in them. Radiology managers from across all Spire hospitals have fortnightly meetings to discuss issues, ideas and practices.

Leaders encouraged staff to take on more senior roles and were supported with any training needs to achieve this. Mentoring was also given for staff who were both on induction and in formal training programmes.

Staff said the new leadership team created a good atmosphere, were visible, friendly and felt the difference they had made.

For wider hospital leadership please see main surgery report.

Vision and Strategy

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

The department manager had identified areas for improvement such as the CT protocol, which can cause delays if the availability of radiologist with speciality areas were not available to provide a vetting process for images. Their proposed strategy to address this was to develop radiographers to be able to vet imaging requests under a new protocol with specific parameters and to upskill staff in order to do this. Additionally, there was the proposal to re write the departments Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) policy.

The radiography information system (RIS) was due to be replaced as it is not currently supported by newer computer operating systems.

The department would like to offer more service days but recruitment of suitable staff is hindering this. There is a current known national shortage of radiographers.

We also reviewed the service's vision and strategy document for 2021, which focused on clinical quality and excellence to improve patient experience, health and safety, improving staff engagement and satisfaction, Improving the consultant experience, improving revenue and managing costs.

For wider hospital vision and strategy please see main surgery report.

Culture

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

Good

Diagnostic imaging

Staff in the department stated they felt there was a good open and honest culture and they had a positive relationship with their manager. They said they felt the new leadership team had made a positive difference and created a good atmosphere. Staff were focussed on patient care and had polite and positive interactions with them. Patients we spoke to felt confident they could raise any concerns or complaints if required without fear. The hospital has a 'Freedom to speak up guardian' and staff were aware of them.

The service promoted equality and diversity and it was part of mandatory training. Managers and staff promoted inclusive and non-discriminatory practices. The provider had committed to meeting racial equality standards and had completed a WRES (Workforce Race Equality Standard) report and action plan for 2021/2022.

For wider hospital culture please see main surgery report.

Governance

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

We viewed a number of policies provided by the hospital including; radiology reporting policy, consent policy, pain management policy, infection prevention and control policy, concerns and complaints management policy, adult safeguarding policy and chaperone policy. All the policies had implementation and review dates, they contained references from national bodies such as the National Institute for Health and Care Excellence (NICE), Medicines and Healthcare products Regulatory Association (MHRA) and Ionising Radiation Medical Exposure Regulations IR(ME)R.

The Ionising Radiation Medical Exposure Regulations (IR(ME)R) policy was comprehensive and adhered to the 2017 regulations. The policy contained clear guidance on what staff competence levels could complete which procedures.

The service operated a clinical governance and assurance framework to assure the hospital of the quality of services provided. At board level quality monitoring was through the clinical governance and safety committee. At a clinical level quality assurance was also discussed at the medical advisory committee meetings and cascaded to staff via monthly team meetings.

For wider hospital governance please see main surgery report.

Management of risk, issues and performance

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

Medical physics and radiation protection advice were provided by service level agreement (SLA) with a radiation protection advisor (RPA) from an external NHS trust. The imaging manager stated there was a good working relationship with the RPA and they can be contacted easily for any advice. The RPA report dated January 2021 found no major concerns with the imaging equipment in the department. The imaging manager was also the radiation protection supervisor but this role would be taken on by the deputy imaging manager soon.

For wider hospital management of risk, issues and performance please see main surgery report.

Good

Diagnostic imaging

Information Management

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

The service collated data on patient radiation doses to inform patient safety. The service has a quality assurance log for imaging machines which was completed well and showed machines were within acceptable tolerance for use. Specific imaging systems had support staff to assist with any IT related issues that may arise.

All staff in the department have access to audits and were encouraged to participate in audits to promote teamwork.

Evidence of incident investigations relating to X ray doses showed reporting processes were followed and consideration was given to whether criteria was met to then send required notifications to statutory bodies, in accordance with guidance and legislation.

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

For wider hospital information management please see main surgery report.

Engagement

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

Leaders carried out twice weekly 'walk rounds' across the hospital site, engaging with patients and staff gathering feedback. There was a patient forum quality improvement project to understand the patient experience of discharge process and identify if improvements could be made in the discharge process. The findings were that all patients who participated in the survey reported they were happy with the discharge process and did not have suggestions for improvement. It was not stated how many patients participated in the survey.

Leaders collaborated with partner organisations to help improve services for patients. They had a good working relationship with the local acute NHS trust. The service has an external pool of radiologist to provide reporting on scans, through a service level agreement (SLA) with an external NHS trust.

The hospital had a workforce race equality standard report and action plan, demonstrating leaders were aware and committed to equality. Leaders engaged with staff using a variety of methods, including; annual staff surveys, team meetings, electronic communication, newsletters, staff notice boards and informal discussions. Staff felt their view and opinions were listened to and felt valued.

For wider hospital engagement please see main surgery report.

Learning, continuous improvement and innovation

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

Good

Diagnostic imaging

Staff said training was good and met their needs and felt management were knowledgeable and approachable for advice and learning opportunities. All staff focused on continually improving the quality of care for patients.

The diagnostic imaging department offered training opportunities which helped to develop the skills and offered career progression to individuals in the team.

Leaders monitored the patient experience through surveys, feedback and complaints.

For wider hospital learning, continuous improvement and innovation please see main surgery report.

Good

Services for children & young people

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

Are Services for children & young people safe?

Good

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

Mandatory training

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

Staff received and kept up to date with their mandatory training. Staff completed 14 mandatory training modules which included equality and diversity, infection control and safeguarding children and adults level two. The hospital submitted data which showed for the outpatients department (including children and young people's service) only five modules met the 95% compliance target, however, seven modules were at 92% compliance. The modules with the lowest compliance were information governance (83%) and quality improvement (52%). The hospital told us that the quality improvement module had been recently introduced and therefore not all staff had been able to complete it. They also stated the training year ran until 31 March and they were confident staff would reach the 95% compliance target by this date.

The hospital had recently introduced new simulator adult and paediatric basic life support training for all staff and had achieved 82% compliance for staff in outpatients (including children's and young people's service). This was to replace the previous face to face annual training and would be completed quarterly to more frequently refresh skills and knowledge. The hospital told us that the compliance rate for basic life support training was impacted by staff on maternity leave, but a fully qualified resus team were on duty every day.

Nursing staff received and kept up-to-date with their mandatory training. The lead nurse for children and young people held advanced life support training. Adult outpatient staff overseeing clinics for children and young people held safeguarding children level two training and paediatric basic life support training. This was highlighted on the staffing boards in each outpatient area.

Medical staff received and kept up-to-date with their mandatory training. Medical staff who cared for children and young people required paediatric basic life support and safeguarding children level three training. We reviewed five recruitment and training records for medical staff caring for children and young people and found all staff had the training required and an up to date appraisal which included working with children and young people. Details of this training were uploaded to an electronic system and medical staff who did not have the required training were not able to book children and young people appointments.

Good

Services for children & young people

Safeguarding

Staff had training on how to recognise and report abuse and they knew how to apply it.

The service had designated the director of clinical services as the hospital lead for safeguarding children and adults. The lead paediatric nurse supported this role, and both held safeguarding children level four training. Staff we spoke to across the hospital knew who the safeguarding lead was and how to raise concerns. The service had not reported any safeguarding children concerns in the last 12 months.

Nursing staff received training specific for their role on how to recognise and report abuse. All staff were expected to complete safeguarding children and adults level two training. The compliance rate for outpatients (including staff working in the children and young people's service) was 92%, below the hospital target of 95%. The training year ran until 31 March 2022 and the service were confident the compliance target would be met. Safeguarding children and adults training level three training had been completed by nine of the outpatient staff.

Medical staff received training specific for their role on how to recognise and report abuse. Medical staff caring for children and young people held safeguarding level training as a condition of their practising privileges. We reviewed five consultant training records, and all held up to date safeguarding children level three training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service had a safeguarding children policy which was up to date and detailed national and local arrangements for safeguarding children. Staff told us they knew how to access this.

The hospital followed Spire Healthcare corporate recruitment policies to ensure staff with the right competencies and skills were recruited and Disclosure and Barring (DBS) checks were carried out on all staff.

Cleanliness, infection control and hygiene

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

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

We observed all outpatient areas treating children and young people were clean and chairs and equipment were wipeable.

Cleaning records were up-to-date. We observed a cleaning schedule for a paediatric equipment trolley was fully completed.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed three members of staff in clinic and all used personal protective equipment and were bare below the elbows to prevent cross infection.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed staff cleaning equipment after each use including baby weighing scales and examination trolleys.

Due to the COVID-19 pandemic, children's toys were not readily available in the clinic rooms or waiting area. However, a selection of wipeable toys were available if needed and were cleaned after use.

Good

Services for children & young people

The hospital took precautions to minimise the infection risk of COVID-19 which included asking all patients and visitors to provide evidence of lateral flow tests, ensuring hand sanitiser was available and providing masks for all patients and visitors. We observed staff ensured social distancing in the waiting areas.

Environment and equipment

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

The service had suitable facilities to meet the needs of children and young people's families. We observed safety measures such as window restrictors and warnings on hot drink machines to ensure the safety of children and young people.

The service had enough suitable equipment to help them to safely care for children and young people. There was a paediatric equipment trolley available in the clinic with growth charts, measuring tapes, ophthalmoscopes and sampling equipment.

Resuscitation equipment specific for children of all ages was available in the children's outpatient area. Records showed these were sealed with a tamper evident sealed and completely checked once a month. We completed a check on the bag and found equipment was present, in good working order and within the expiry date.

We observed a children and young people's allergy clinic where the consultant supplied and managed all their own equipment.

Staff disposed of clinical waste safely. We observed staff disposing of clinical waste in the correct waste bins.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks.

Staff completed risk assessments for young people aged 16 and over to be cared for in adult areas. There was a standard risk assessment which was completed to assess if young people could be cared for in adult wards in line with Spire healthcare corporate policy. This included an assessment of physical needs, behaviour and ability to self-advocate to follow an adult pathway. We observed this risk assessment had been completed fully for a young person admitted to an adult ward during our inspection.

Children and young people under the age of 16 were not admitted to the hospital. A registered children's nurse was available for all children and young people under the age of 16 having an invasive procedure.

The service had a transfer agreement with the local NHS trust to transfer any child or young person that became unwell.

Resuscitation simulations were carried out regularly and followed up by an action plan detailing areas for improvement. This included scenarios specifically for children and young people.

Nurse staffing

The service usually had enough nursing staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment.

Good

Services for children & young people

The service usually had enough nursing and support staff to keep children and young people safe. Children were seen in the outpatient, physiotherapy or imaging department for consultation only. There was one lead nurse for the children and young people's service who covered the consultant led clinics undertaking invasive procedures such as blood tests. If the lead children and young people's nurse was on holiday or sick leave procedures such as blood tests were delayed until they returned to work.

Young people over the age of 16 could be seen in outpatients for minor invasive procedures or admitted for treatment providing a risk assessment had been carried out by the lead nurse before the appointment. These patients were cared for by adult nursing staff with competencies in caring for children and young people.

Medical staffing

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

All clinics were consultant led and worked flexibly.

All consultant seeing children and young people held practising privileges which included a review of their practice, paediatric basic life support and safeguarding children training. Consultants who did not hold this training could not book children into the hospital. Records

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

Patient notes were comprehensive, and all staff could access them easily. We reviewed one set of inpatient notes for the only young person admitted to the hospital during our inspection. The notes included pre-assessment checks, appropriately completed consent forms and medical and nursing records.

Medicines

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

The only medicine used in the children and young people's service was local anaesthetic cream used to numb the skin before painful procedures such as blood tests. Patient Group Directions (PGD) were used for staff to administer this. A PGD provides a legal framework that allows some registered health professionals to supply and/ or administer a specified medicine(s) to a pre-defined group of patients, without them having to see a doctor. We reviewed the two PGDs in use for the service and found they were authorised correctly and due for review in 2023.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses.

The service reported three incidents in the last 12 months relating to children and young people, these included two related in laboratory samples and one was a cancellation on the day of surgery due to the young person being unwell.

The staff we spoke with could give examples of incidents and knew how to report these.

Good

Services for children & young people

Are Services for children & young people effective?

Inspected but not rated

Inspected but not rated

Evidence-based care and treatment

The service provided care and treatment based on national guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed a selection of policies and guidance related to children and young people and found they were within their review date.

The hospital did not take part in any national audits or reviews relating to the care of children as these were not relevant to the type of service they provided.

Nutrition and hydration

Staff gave children, young people and their families enough drink to meet their needs.

Water dispensers and hot drink machines were available throughout the outpatient waiting area for patients and families to use when they attended clinic appointments.

Pain relief

Staff used pain relieving medicine to prevent children and young people experiencing pain during invasive procedures.

Staff administered suitable pain relief such as local anaesthetic creams before painful procedures. We observed a children's blood test clinic where local anaesthetic cream was applied beforehand alongside the use of non-pharmacological pain relief such as distraction techniques.

Patient outcomes

There was no patient outcome monitoring for the children and young people's service due to the limited size of the service.

The service was very limited to outpatient consultations and therefore patient outcome data was not collected.

The service did not hold any accreditations as these were not relevant to the service provided.

Competent staff

The service made sure staff were competent for their roles.

Radiology staff and nursing staff across outpatients, recovery and the wards held competencies to care for children and young people signed by the lead children's nurse. We reviewed the competency and training for a healthcare assistant

overseeing an outpatient clinic while on inspection and found these had been completed. The service submitted a list of outpatient staff after the inspection which showed all competencies had been completed. Staff received appraisals allowing them to review their clinical practice and identify any learning needs. The appraisal rate for outpatients was 100% which included the lead children's nurse.

All medical staff caring for children and young people had experience and qualifications to care for them effectively. The hospital only granted practicing privileges to doctors who were licensed and registered with the General Medical Council (GMC), held a substantive post within the NHS or could demonstrate independent practice over a sustained period and held relevant clinical experience. The booking system would not allow doctors without paediatric practicing privileges to book to see a child or young person.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families.

Staff throughout the hospital knew the lead children's nurse and told us they were confident to communicate or escalate any concerns to them. We observed a good working relationship between nursing staff, imaging staff and consultants in the service.

Seven-day services

The service was not designed to provide a seven day service.
Appointments could be made outside school hours to minimise disruptions to schooling.

Health promotion

The service displayed a range of health promotion information such as healthy eating, safety of button batteries and mental health for children and young people in clinic areas.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

The hospital had a policy on consent including children and young people under the age of 16 and staff knew how to access this. The Spire Healthcare consent policy provided guidance for staff obtaining consent from children and young people under the age of 16, including the principles of Gillick competence and parental responsibility. Gillick competence is a legal ruling whereby clinicians may accept consent from a child or young person under 16 years of age, who has been assessed as competent to understand the implications of consent and cannot be persuaded to involve parents in care and treatment decisions. The understanding required for different interventions will vary considerably and therefore a child under 16 may have the capacity to consent to some interventions but not others.

The service displayed an information poster for children and young people on consent in the waiting room. This covered topics such as 'what is consent', 'can I give consent' and 'what happens in an emergency'.

Are Services for children & young people caring?

Good

Services for children & young people

Good

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

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity.

Staff took time to interact with children, young people and their families in a respectful and considerate way. Throughout the inspection, we observed medical and nursing staff talking kindly to children, young people and their families.

Staff respected the privacy and dignity of children and young people. Doors were kept closed during consultations so that conversations could not be overheard. We observed doctors being mindful of maintaining dignity during examinations such as rolling trouser legs up rather than requiring a child or young person to undress.

The hospital provided chaperones during clinic; we saw chaperone signs in all the clinics we visited.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress.

Staff gave children, young people and their families help, emotional support and advice when they needed it. In all the interactions we observed, we saw staff taking time to explain procedures to children and young people and provide reassurance when needed.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their families, wellbeing. The lead nurse told us about a recent clinic appointment where a child with autism was afraid to come into hospital. The parent contacted the service in advance because the child had not been able to attend any clinic appointments at any hospital. The lead nurse provided the family with photos to explain what would happen during the appointment. This was successful and enabled the child to safely attend for their appointment. The lead nurse planned to use this across the service in the future.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff talked with children, young people and their families in a way they could understand. We observed three consultations with two different consultants and found they involved children and young people in the consultation using age appropriate language. We saw consultants and nursing staff addressed children and young people directly and coming down to their level to put them at ease. One young person we spoke with commented that they were pleased the questions were directed to them as it made them feel treated as an adult.

Consultants allowed ample time for parents and carers to ask questions and we observed they answered these using straightforward explanations.

Good

Services for children & young people

Are Services for children & 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

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

Outpatient clinics for children and young people were predominantly planned around consultant availability and there were no weekend appointments for children and young people. However, some appointments were available outside of school hours and we observed a consultant making an appointment for a young person in the school holidays, so it did not affect schooling.

Facilities and premises were appropriate for the services being delivered. There were spacious nappy changing facilities available and access for pushchairs to clinic rooms via a lift if needed. There was no dedicated room or area for breastfeeding mothers, but staff told us they would find a quiet, private space if needed.

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services.

The main outpatient area used for children and young people's clinics were designed to meet the needs of children. There was child friendly decoration on the walls, child's seating and activity packs, colouring sheets and crayons available. There was no specific provision for older children, but staff told us they usually brought their own electronic devices with them.

Staff made an effort to meet the individual needs of children. The lead nurse gave an example where a child with autism was afraid of coming into hospital. The lead nurse sent the family some photos of the hospital before the appointment to help them understand what would happen and allow them to attend the appointment.

Staff made sure staff, children, young people and their families could get help from interpreters or signers when needed. The service had access to a telephone interpreting service where children and families first language was not English.

Access and flow

People could access the service when they needed it.

Appointments for children and young people were available throughout the week.

All children and young people seen at the hospital were privately funded and there were minimal waiting lists. Treatment was progressed as quickly as possible subject to a risk assessment.

Good

Services for children & young people

Learning from complaints and concerns

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

The service used patient feedback surveys to obtain the views of children, young people and their families. These were completed online and collated by the Spire Healthcare corporate team and then shared with the service.

The survey reviewed eight key areas including timeliness of appointment, booking, hospital facilities, information provided, parking, treatment and arriving at reception. Data from April to December 2021 showed the service performed worse than the Spire Healthcare national average in seven of these areas and performed better than the national average for booking of appointments (81% against 77%). The survey results showed most of these measures had significantly improved since April 2021 with aftercare improving from 63% to 87% and hospital facilities improving from 42% to 67%. Data reflects those patients rating the service excellent. Parking and arriving at reception were the areas rated lowest and satisfaction had decreased since April 2021.

The service had developed an action plan from patient feedback results which highlighted four key areas including toys available for children, the noise of the computerised tomography (CT) machine, both parents being able to attend an appointment and reception staff not being friendly. The action plan showed improvements had been made for activities being available for children and preparing children for the noise of the CT machine and the two other areas were in progress. The service also had a 'you said, we did' poster showing actions to two recent pieces of feedback.

Are Services for children & young people well-led?

Good

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

Leadership

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

The service was led by a paediatric nurse who had experience in caring for children and young people of all ages. However, due to size of the service only one paediatric nurse was employed which meant if the nurse was off sick or on holiday, clinics for children where invasive procedures such as blood sampling took place would be cancelled. This left the service very dependent on one nurse.

The lead paediatric nurse was well respected throughout the hospital and staff told us they felt comfortable to approach them to ask for advice or guidance.

The lead nurse also had support from other lead nurses in the local area and wider Spire hospital network. They told us that they had frequent meetings which were helpful and supportive.

The lead paediatric nurse was managed by the outpatient manager and also told us they felt able to approach the director of clinical services with any issues.

Good

Services for children & young people

Vision and Strategy

The service did not have a vison and strategy for what it wanted to achieve.

Due to the limited nature of the service, there was no vison or strategy for what the children and young people's service wanted to achieve.

All other arrangements for vision and strategy were the same as the surgery core service. Please refer to the surgery report for more details.

Culture

Staff felt respected, supported and valued. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with told us they felt respected, supported and valued. Ward managers were accessible and visible throughout the hospital.

Staff told us and we observed positive working relationships between nursing and medical staff throughout the service.

Patients and their families could raise concerns without fear. Patients we spoke with told us they were comfortable to raise any concerns or issues with staff.

The staff sickness rate was 4% in outpatients which included the children and young people's service. The hospital did not give a target for sickness rate.

Governance

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

The hospital had a children and young people clinical governance meeting which fed into a quarterly governance committee meeting attended by the hospital director, clinical governance lead, medical advisory committee (MAC) chair, director of clinical services and heads of department. We saw the paediatric standards and governance was a standing agenda item and covered issues such as safeguarding alerts, consultant training and updated policies.

Management of risk, issues and performance

Leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact.

The hospital held a risk register which was regularly reviewed to ensure risks were monitored and managed. The lead nurse told us they could escalate risks to be added to the risk register if needed. There were no direct issues relating to children and young people on the risk register.

Learning, continuous improvement and innovation

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

Good

Services for children & young people

The paediatric lead nurse was passionate about the service and ensuring high standards of care. There was evidence that the service had used patient feedback to improve the quality of the service.

All other arrangements for learning, continuous improvement and innovation are the same as the surgery core service. Please refer to the surgery report for more information.

For information management and engagement please see surgery.